A report based on an investigation into the implementation of Children First: National Guidelines for the Protection and Welfare of Children.

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Ombudsman for Children's Office

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FOREWORD

The State has an obligation under Article 3 of the UN Convention on the Rights of the Child to ensure that in all actions concerning children, whether undertaken by public or private institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. This principle is undisputed. There is no disagreement regarding the fact that children's best interests must be at the heart of our child protection and welfare services.

In particular, Article 3(3) of the UN Convention provides that:

> "States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision."

This provision of the UN Convention articulates a basic principle of sound administration in the design and provision of child care and child protection services: standards governing the provision of those services must be set; services must comply with those standards; and the State must provide for adequate supervision and monitoring.

This report is the result of an investigation into the implementation of Children First, National Guidelines for the Protection and Welfare of Children, which was published in 1999.

Individual complaints to the Ombudsman for Children can highlight a deficiency in policy, practice or legislation. In this case the investigation was conducted under section 10 of the Act which provides that I can initiate an investigation of my own motion. Own motion investigations are particularly useful where, as in this case, children and families who may be affected are less likely to make a complaint. This is also the first systemic investigation carried out by the Ombudsman for Children's Office. By definition this recognises the Ombudsman's potential to induce broader change in the administrative system that benefits more than one individual child.

Some of the conclusions in this report are positive. It is recognised that substantial efforts have been made at various times since 1999 to implement Children First. However, some of its conclusions are negative and a number of findings of unsound administration have been made.

Section 7 of the Act provides that the Ombudsman for Children shall encourage public bodies to develop policies, practices and procedures designed to promote the rights and welfare of children. In the spirit of this provision I make recommendations for positive change for the future.

The qualities of childhood include immaturity, innocence, trusting and fun loving and it is these very qualities that people can seek to abuse. While we have had difficulty accepting the reality of child abuse in Ireland we must accept that children deserve the highest level of protection from our laws, policy and practice.

Much needs to be done to improve protection and promote children's rights and welfare. This is not simply a matter of resources. Some of the problems identified - variable practice, a lack of internal scrutiny, a failure to get different agencies working together - indicate a need for a change of culture and attitude.

I am very conscious that this investigation examined a time period when health and social services were undergoing fundamental reform, in particular with the creation of the Health Service Executive. It is recognised nationally that the health service is a complex organisation but it is also recognised internationally that change is a constant in any health service. In the context of the wider reform how did children fare?

I conclude from this investigation that child protection services were not at times given priority in this reform process. At the same time, I acknowledge that since the launch of this investigation that a number of initiatives are currently underway that have positive potential. It is important that this positive potential is realised. To date, there has been no shortage of analysis of what the problems are, but far less action to tackle them.

I am aware that the HSE is undertaking a Strategic Review of the Delivery and Management of Child Protection Services. It is important that this review considers all options and asks new questions. That should include whether child protection services are best delivered within the context of the HSE and, if concluded that they are, how to ensure that a focus on them is not lost amid wider concerns about health services.

I am grateful for the cooperation of all those who met with my Office during this investigation and all those who supplied information and documents.

It is impossible to protect all children from harm at all times. It is, however, within our power to ensure that the systems we establish to protect them are as strong as they can be and exhibit the essential characteristics of sound administration outlined above. It is my hope that this report contributes positively to child protection in Ireland.

Emily Logan
Ombudsman for Children

GLOSSARY OF TERMS USED

CCM Child Care Manager – an official in Local Health Offices responsible for, among other things, managing the Child Protection Notification System and coordinating inter-agency approaches to child protection.

CPNS Child Protection Notification System – the system used for notifying cases of suspected child abuse.

DoHC Department of Health and Children – the Department with policy responsibility for, among other things, child protection issues.

ERHA Eastern Regional Health Authority – the Eastern Regional Health Authority was an authority that supplied health and social services, including child protection services, in the counties of Dublin, Kildare and Wicklow in the period 2000 to 2004.

GSI Garda Síochána Inspectorate – the body responsible for inspecting an Garda Síochána.

HeBE Health Boards Executive – formally established in 2002, this body was a vehicle for coordinating the work of the regional health boards. It was abolished when the Health Service Executive was created on 1 January 2005.

HSE Health Service Executive – the national body responsible for the provision of health and social services, including child protection services.

LCPC Local Child Protection Committee **–** an interdisciplinary committee that Children First envisaged would exist in every community care area to foster cooperation locally as regards child protection.

LHO Local Health Office – there are 32 Local Health Offices in the Health Service Executive. They provide, among other things, child protection services at local level.

NIAG National Implementation Advisory Group – a group involving the health boards and the Department of Health and Children which advised on the implementation of Children First up to the end of 2002.

OMCYA Office of the Minister for Children and Youth Affairs – this Office is responsible for discharging a number of functions relating to children in fields such as health and justice.

PSW Principal Social Worker – the highest grade of social worker. Each Local Health Office has a Principal Social Worker.

RCPC Regional Child Protection Committee – an interdisciplinary committee that Children First envisaged would exist in every health board area to facilitate coordination of child protection work on a regional basis.

SSI Social Services Inspectorate – the body responsible for inspecting social services in Ireland. It was set up in 1999 and was originally part of the Department of Health and Children. In May 2007 it was established on a statutory basis as the Office of the Chief Inspector of Social Services within the Health Information and Quality Authority.

SWIS Social Work Information System – a database used by social workers in most of the State.

CHAPTER I. BACKGROUND TO THE INVESTIGATION

(a) Announcement of the preliminary examination

On 19 November 2008 the Ombudsman for Children wrote to

- Mary Harney TD, Minister for Health and Children;
- Barry Andrews TD, Minister for Children and Youth Affairs;
- Professor Brendan Drumm, of the Health Service Executive (HSE) and
- all Child Care Managers (CCMs) in all 32 Local Health Offices of the HSE

informing them that she was launching "an investigation into the state of implementation of Children First: National Guidelines for the Protection and Welfare of Children." This was also announced by press release issued the next day.

Children First is, as its name suggests, a document setting out the State's guidelines on the protection and welfare of children. It provides detailed guidance to HSE staff, an Garda Síochána and others who provide services to children. Its goals are to ensure that children are protected from abuse and that their welfare is promoted.

The investigation was conducted under s.10(1)(a)(ii) of the Ombudsman for Children Act 2002 which empowers the Ombudsman for Children to conduct an investigation of her own motion. Own motion investigations are particularly useful where, as in this case, children who may be affected are less likely to make complaints. They also provide an opportunity to examine whether there are systemic problems which may give rise to difficulties for many children.

The reasons cited by the Ombudsman for Children for initiating the investigation included:

- the serious concerns raised by the outcome of the Office of the Minister for Children and Youth Affairs (OMCYA) review of Children First published in July 2008 and
- information which had recently come to the attention of the Ombudsman for Children which indicated that Children First was not being fully implemented.

(b) The preliminary examination

The first stage in any investigation is a preliminary examination. As part of the preliminary examination, the Ombudsman for Children in her letter to CCMs of 19 November 2008 asked them to provide within 21 days:

- documents setting out the child protection policy, local procedures and guidance being used in their areas;

- any other relevant document or information that demonstrates the implementation of child protection guidelines in their areas and
- the steps that had been taken in their areas to implement the Children First Guidelines.

This Office has formal liaison arrangements with the HSE. However, it can be appropriate from time to time to hear from HSE staff directly. This was such a case. The Ombudsman for Children values the expertise of CCMs and judged it appropriate to contact them in order to understand the procedures that were being applied locally and the steps taken locally to secure implementation.

Galway, Sligo/Leitrim, Mayo and Roscommon responded by the end of the 21 day deadline on 10 December 2008. By mid-January 2009 all CCMs had responded.

In some cases, the delay in submitting responses was due to Local Health Offices working with each other. For example, North Lee, South Lee, North Cork, West Cork and Kerry agreed to send a uniform response on the basis that practice was standard across those areas. This was reasonable as these areas had all been part of the one Health Board and therefore had a history of working together on child protection issues.

In other cases, the delay was due to an instruction issued by the HSE on 8 December 2008 asking HSE Assistant National Directors to ensure that all responses were sent through to Local Health Managers and the relevant HSE Assistant National Directors "in order to ensure a cohesive approach... from a governance perspective." In other correspondence this was described as a "cohesive and coordinated response."

By the time that the instruction had been put into effect, some responses had already been received by this Office from CCMs. The implementation of the instruction caused some delay in the receipt of the outstanding responses. It also caused some confusion, as reminder letters were sent by this Office to CCMs who believed that their responses had already been transmitted to this Office, when in fact they had not.

However, this Office has no evidence that the responses were edited or altered as a result of the coordination. Coordinated responses varied in style and format and – like uncoordinated responses – were at times frank about difficulties in implementation. Some coordinated responses were strong, others less so. Helpfully, in one HSE region, the person coordinating the responses specifically volunteered that he had neither amended nor deleted nor yet added to any of the responses.

What did occur was that the HSE analysed the responses forwarded by CCMs themselves, and included this in the Social Work Survey 2008.[1] The Ombudsman for Children welcomes this. *However, it is recommended for the future that responses be forwarded directly to this Office. In the event that the HSE centrally wishes to be aware of responses given, this would best be done by copying management in on the responses.*

[1]Social Work and Family Support Survey, Health Service Executive, April 2009, (unpublished).

(c) The decision to move to full investigation

The preliminary examination involved the analysis of all the materials submitted by all 32 Local Health Offices in response to this Office's request.

In order to do this, a template was devised against which all local procedures and other documents submitted demonstrating implementation were assessed in detail. This involved checking the compliance of local procedures and such other documents with Children First under 39 different headings, and as against over 110 detailed criteria drawn from Children First.

An overall assessment was also conducted of the documents provided by each Local Health Office. It listed off the primary concerns related to each area and also specifically analysed some key issues, such as provision for Garda/HSE cooperation. This work raised a number of concerns regarding the non and partial implementation of Children First. The key findings in this regard are outlined in Chapter IV of this report.

In view of this, the Ombudsman for Children concluded that there was sufficient evidence of non-implementation and/or partial implementation of Children First to proceed from preliminary examination to investigation and that a child or children may have been adversely affected. This was announced in letters to CCMs, the OMCYA and HSE on 17 July 2009.

The investigation focused in particular on:

- the extent of non-implementation of Children First;
- the extent and possible implications of partial implementation of Children First;
- identifying the obstacles/barriers and difficulties associated with implementation of Children First; and
- identifying the steps taken by the Department of Health and Children (in particular the OMCYA) and the HSE to progress implementation of Children First and address any obstacles to implementation that may have been identified.

As part of the investigation, meetings were held with nine CCMs. Whereas at preliminary examination stage the focus was particularly on implementation in local procedures and other documents demonstrating implementation, the purpose of the investigation meetings was to examine implementation on the ground. This Office operates within limited resources. It was therefore not possible to conduct investigation meetings with every CCM. Nor was it possible to inspect implementation in practice through, for example, an analysis of files – such work would more be more typical of an inspectorate than an Ombudsman for Children.

The CCMs selected were from:

- Dublin North;
- North Lee;
- Dublin West;
- Laois/Offaly;
- Dublin South City;
- Cork North;
- South Lee;
- Dublin North City;
- Dun Laoghaire.

The above involved a mix of urban and rural areas. However, some areas were selected because of specific difficulties that they had reported with implementation, because of distinctive features associated with their implementation or because they had been particularly successful at implementation. For reasons which will become apparent, this resulted in a particular focus on urban areas, particularly the Greater Dublin area.

As well as nine meetings with CCMs, the Office wrote substantively to various CCMs and Local Health Managers on 21 occasions to clarify various different matters arising.[2] The Office also corresponded with the HSE at national level, the OMCYA, an Garda Síochána and the trade union IMPACT on a number of occasions and also met with officials of each of these organisations.

The Office also sought additional materials from the HSE and the OMCYA on issues such as how responsibility for implementation of Children First was delegated following the abolition of the Health Boards and the creation of the HSE, copies of reviews and inspections undertaken regarding the implementation of Children First, copies of the latest HSE reviews of adequacy of services for children and families (for 2007 and 2008) and minutes of meetings of interdepartmental groups to implement Children First.

In the course of this work a number of further documents were submitted by OMCYA officials and by HSE officials both locally and nationally. The Ombudsman for Children is grateful for their cooperation during the investigation, and wishes to recognise the importance of their work in protecting children and promoting their welfare.

Their cooperation helped to make clear how Children First was – and was not - implemented since its publication in 1999. This is set out in Chapter III of this report.

[2] The Office also corresponded with Local Health Managers and Child Care Managers at the end of the investigation. See under “Final Steps” below.

Their cooperation also helped to provide further qualitative information on the current implementation of Children First at Local Health Office level. This is set out, along with the main results of this Office's examination of local procedures and other documents demonstrating implementation of Children First, at Chapter IV of this report.

(d) Final steps

At the end of the investigation, any adverse findings were put in writing to those against whom they were made, in compliance with s.13(6) of the Ombudsman for Children Act 2002. Some other matters were checked with interviewees for accuracy. Comments received as a result of this process were carefully considered by this Office before finalisation.

Following this, the report was sent to the HSE and the OMCYA so that it could give its response to any recommendations made.

CHAPTER II. CHILDREN FIRST OUTLINED

Children First was not the first national guidance on child protection work. The first guidelines were issued in 1977.[3] These were replaced by further guidelines in 1987,[4] which were supplemented by guidelines on health board cooperation with an Garda Síochána issued in 1995.[5]

Further, details on these earlier guidelines and, in particular, the difference between the 1987 and 1995 Guidelines, on the one hand, and Children First, on the other, is provided at **Annex A**.

In 1996 the Department of Health and Children published a consultation paper on mandatory reporting entitled *Putting Children First*.[6] As its name suggests, mandatory reporting means making it an offence not to report suspected cases of child abuse. Ultimately, the Government decided not to introduce mandatory reporting. Instead, a number of important initiatives were taken. One of these was to appoint CCMs to coordinate inter-agency approaches to child protection in each community care area of the former Health Boards. Another was to review the 1987 and 1995 Guidelines.[7] It was this review that gave rise to Children First, which was published in 1999.

Children First is by far the most comprehensive and far-reaching document on child protection and welfare in the history of the State. The length of the document alone makes this clear. The 1987 Guidelines were 48 pages long. Children First is 166 pages long. What appears below is a summary of its most important aspects, along with an explanation of how Children First improved on the 1987/1995 Guidelines.

Like the 1987 Guidelines, Children First does not introduce mandatory reporting. The document describes the duty to report as a duty of society – as opposed to a legal duty to be enforced on pain of criminal sanction.

Chapter 1 of Children First makes clear that this societal duty applies to health board personnel, an Garda Síochána, public agencies, voluntary and community organisations and private citizens. By contrast, the 1987 Guidelines were focused principally on social workers and various health care professionals. They only mentioned voluntary organisations fleetingly – and did not address themselves to private citizens at all.[8]

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[3] Memorandum on Non-Accidental Injury to Children, Department of Health, 1977.
[4] Department of Health, Guidelines on Procedures for the Identification, Investigation and Management of Child Sexual Abuse, 1987.
[5] Notification of Suspected Cases of Child Abuse between Health Boards and Gardaí, Department of Health and the Garda Síochána, 1995.
[6] Putting Children First, a Discussion Document on Mandatory Reporting of Child Abuse, Department of Health and Children, 1996.
[7] These initiatives were announced in a policy document, Putting Children First – Promoting and Protecting the Rights of Children, Department of Health and Children, 1997. This should not be confused with the consultation document, from the previous year, also entitled Putting Children First.
[8] See p.7 of the 1987 Guidelines.

Chapters 1 and 2 also explain the main legislation relevant to child protection work, such as the Child Care Act 1991, the Protections for Persons Reporting Child Abuse Act 1998, the Domestic Violence Act 1996, the Freedom of Information Act 1997 and the Data Protection Act 1988. None of these Acts had been passed at the time of the 1987 Guidelines.

Chapter 3 defines what child abuse is – explaining, often with examples, the key concepts of neglect, emotional abuse, physical abuse and sexual abuse. While these terms were also used in the 1987 and 1995 Guidelines, greater detail was provided on what they meant. For example, Children First makes clear that exposure to domestic violence and the premature imposition of responsibility on a child are emotional abuse.

Chapter 4 is about when and how to report child abuse. It makes clear that child abuse should be reported when there are reasonable grounds for concern that a child may have been abused, is being abused or is at risk of abuse. By contrast, the 1987 Guidelines did not cover historic cases of abuse. That is a significant omission because those who have abused children in the past may also pose a present risk to children.

Critically, chapter 4 also provides guidance on what are reasonable grounds for concern. For example, a specific indication from a child that he or she was abused is a reasonable ground for concern. This was not made clear by the 1987 Guidelines.

Chapter 4 also outlines how to report child abuse and provides a standard reporting form.

Chapter 5 deals with confidentiality, exchange of information and participation by parents/carers. It stresses that information regarding concerns or assessment of child abuse should be shared on a "need to know" basis. It explains that giving information to others for the protection of a child is not a breach of confidentiality. Critically, it also explains that no undertakings regarding secrecy should be given to a child. It also stresses the general need to inform or consult parents or carers throughout investigations.

Chapter 6 outlines the role of Health Boards (now, of course, replaced by the HSE), Central Government, an Garda Síochána, schools, GPs, Hospitals, mental health services etc. regarding child abuse. It also requires two important committees. These are:

- **Regional Child Protection Committees** – which were to be established at Health Board level to facilitate cooperation between social workers, an Garda Síochána, probation services, medical practitioners, nursing staff and other relevant professionals. These Committees were meant to issue guidance on inter-disciplinary and inter-agency procedures, review annually the child protection work in the region and to develop a work plan for the coming year.

- **Local Child Protection Committees** – These were meant to involve a similar range of professionals, but at a community care area level. Essentially, these committees were designed to bring together all key players at local level to provide a forum for the sharing of knowledge and experience on the protection of children. Among the detailed terms of reference suggested for the Local Committees were implementing procedures developed by the Regional Committee and to keep under review ways of

> raising public awareness of child abuse and mechanisms to express concerns about child abuse at local level.

Chapters 7 to 9 concern the responses of the Health Boards (now HSE) and an Garda Síochána to child abuse.

Chapter 7 stresses the importance of family support services to prevent the worsening of difficulties that may be experienced by a family. These services can include support in tackling addiction, managing difficult behaviour or running the home. Children First requires each community care area to have a family support service plan, which should take account of the views of all relevant service providers and representatives of community organisations.

Chapter 8 concerns assessment and management of child abuse. It is this chapter, more than any other, that is meant to guide social workers engaged in child protection.

Upon receipt of a child protection concern, **chapter 8** requires social workers to consider Health Board records at the earliest opportunity. It may also be necessary to contact the public health nurse, area medical officer, child care worker or other Health Board colleague. Non-Health Board professionals may also be contacted, such as teachers or general practitioners.

If, following initial reports or enquiries, it appears that the child is not at risk of abuse, but that there are concerns for his or her welfare, Children First points out that family support services could help to prevent further deterioration.[9]

If a report made to a Health Board indicates immediate and serious risk, urgent action must be taken to protect the child, up to and including an application for an emergency care order under the Child Care Act 1991. If the matter is routine, the concern should be followed up "as soon as possible." This could involve medical examination of the child, communicating with the family and any professionals involved.

Children First calls this phase of work "*preliminary enquiries*."[10] It also refers to "*initial reports and inquiries*" at this phase.[11]

Chapter 8 also requires the establishment of the Child Protection Notification System. It states that:

> "The Child Protection Notification System is a Health Board record of every child about whom, following a preliminary assessment, there is a child protection concern. A child's name is placed on the Child Protection Notification System by the CCM/designate following completion of a *preliminary assessment*"[12]

[9] See page 70 of Children First at para. 8.8.1.
[10] See the heading of page 69 of Children First.
[11] See page 70 of Children First at para. 8.8.1.
[12] See page 74 of Children First at para. 8.15.1.

It is not necessary for abuse to be confirmed in order for notification to take place – notification can happen where abuse is suspected also.[13]

The procedure envisaged by Children First is that, following preliminary assessment, a social worker notifies the child to the CCM, who then places the child on the Child Protection Notification System. A specific form is provided by Children First to this end.[14]

Children First requires the CCM to convene a *Child Protection Notification Management Meeting*, usually consisting of an inter-disciplinary group of Managers who should "at very close intervals" review all reports of children at risk and advise on management of those cases. It is not clear from Children First whether it, or the CCM, has responsibility for deciding if a child is to be put on the Child Protection Notification System.

Children First requires that "all relevant services and agencies" have 24 hour access to the Child Protection Notification System.[15] This may include medical practitioners, senior nurses, social workers, designated Garda officers and senior staff in the probation and welfare services.[16]

The *Child Protection Notification Management Meeting* is but one of the different meetings envisaged by Children First. Another – particularly important - one is the *Strategy Meeting*. Children First states that a Strategy Meeting should be considered following preliminary enquiries and submission of notification. The meeting is designed to involve all professionals in a case, particularly an Garda Síochána. [17] The purposes of a Strategy Meeting include to share available information, consider legal options, identify sources of further information and allocate responsibilities for further enquiry and to agree with an Garda Síochána how the remainder of the enquiry will be conducted.[18]

The *Strategy Meeting* differs from the *Child Protection Notification Management Meeting*. The latter essentially involves a run through cases on the Child Protection Notification System to take an overview of their management. The Strategy Meeting is focused on a particular case to decide how that case is to be taken forward. A Strategy Meeting is particularly important where a case may have criminal aspects to ensure that the HSE works well with an Garda Síochána and that there is no prejudice to any criminal investigation.

In a section of chapter 8 that follows mention of the Child Protection Notification System and the holding of Strategy Meetings, Children First refers to "*initial* assessments." As we have already seen, "*preliminary* assessments" are envisaged before notification to the CCM. The section on "*initial* assessments" is located in the text in Children First *after* notification to the CCM, which leaves an impression that initial assessments are done after notification and are different to preliminary assessments. Yet the purpose of preliminary assessments seems to

[13] See Appendix 7 to Children First, at page 155, paras 1 to 4.
[14] See page 75 of Children First at para. 8.15.1 and Appendix 8.
[15] See page 157 of Children First at para 12.
[16] See page 157 of Children First at para. 13.
[17] See page 75 of Children First at para 8.16.1.
[18] See page 75 of Children First at para 8.16.2.

be the same as the purpose of an initial assessment: to assess the child's immediate safety.[19] As discussed below, this ambiguity caused real confusion in practice.

Children First states that if, after initial assessment, grounds for concern still exist, a full assessment should be done with a view to creating a child protection plan. This process may include a *Child Protection Conference*. Again, a Child Protection Conference is an interdisciplinary meeting. Like Strategy Meetings, Child Protection Conferences are designed to focus on the case of a particular child. They are nonetheless very different to Strategy Meetings. Strategy Meetings are designed to guide the future investigation of a child protection concern and do not involve parents or carers. Child Protection Conferences occur towards the end of investigations and typically do involve parents or carers. Child Protection Conferences are appropriate when decisions of a serious nature are being considered and the input of professionals from different disciplines and agencies is needed in order to draw up a child protection plan for a child.[20]

Chapter 8 also provides for two types of reviews. First, *Child Protection Reviews* are to occur every six months for children at risk who have been notified and who still reside with parents or carers.[21] Essentially, these reviews are to ensure that children do not linger on the Child Protection Notification System without appropriate action being taken.

Second, *Case Management Reviews* are a systems check which is to be carried out following a serious incident such as when a case of suspected or confirmed abuse results in the death or serious injury of a child or where there is a child protection issue of significant public concern.[22]

Chapter 8 of Children First goes well beyond the 1987 Guidelines. The 1987 Guidelines did have a system for notification – although with far less detail regarding its operation. In particular, the 1987 Guidelines did not require 24 hour access to the notification system. The 1987 Guidelines also did not require Child Protection Notification Management Meetings or the six monthly Child Protection Reviews. Nor was the participation of parents and carers at Child Protection Conferences routinely envisaged. Nor yet did the 1987 Guidelines emphasise the provision of family support services for those cases that did not meet the thresholds for abuse.

Chapter 9 of Children First governs Garda-Health Board relations.

Like the 1995 Guidelines, it requires the Health Board to notify an Garda Síochána of any case where the Board suspects that a child has been physically or sexually abused or wilfully neglected. This must not be left until the Board has confirmed abuse. By contrast, emotional abuse and unintentional neglect need not be referred to an Garda Síochána since they may not involve law enforcement issues. The referral should go from the CCM/designate to the local Garda Superintendent using a standard form. The

[19] See p.77 of Children First at para 8.18.2.
[20] See pp.78-79 of Children First at paras 8.19 to 8.21.
[21] See p.82 of Children First at para 8.24.
[22] See p.83 of Children First at para 8.25.

Superintendent must then appoint a designated Garda to liaise with the social worker dealing with the case – and let the CCM/designate know who this is.

The designated Garda must then make contact with the social worker and they should draw up a joint action sheet. This joint action sheet ensures clarity as to who is to do what – and accountability if tasks are not undertaken as agreed.

The Superintendent must also appoint an Inspector/Sergeant to work with the relevant Social Work Team leader. Their task is to resolve any difficulties that may arise between the social worker and the designated Garda and to manage the investigation.[23]

Children First also lays down a similar procedure for an Garda Síochána to formally notify the relevant Health Board staff. The only difference is that, as well as referring in cases of physical and sexual abuse and intentional neglect, an Garda Síochána must also refer in cases of emotional abuse and unintentional neglect.[24] Although such cases do not normally have criminal aspects, they are nonetheless important from a child protection perspective. Social workers therefore need to be notified.

Children First also provides for a liaison management team consisting of a social work team leader and a Garda Inspector/Sergeant. As explained at **Annex B**, it is not entirely clear whether this is a standing arrangement, or simply a reference to the requirement – stated above – to appoint a social work team leader and a Garda Inspector/Sergeant in the context of each investigation.

Unlike the 1995 Guidelines, Chapter 9 of Children First also stresses the importance of Garda attendance at Strategy Meetings and Child Protection Conferences.[25]

Chapter 9 also provides guidance regarding underage pregnancy.

Finally, Chapter 9 states that where retrospective disclosure is made by adults, serious consideration must be given to the current risk of any child that may be in contact with the alleged abuser.

Chapter 10 provides guidance on specially vulnerable children, such as children with disabilities, homeless children, children in foster care and children in residential settings. The 1987 Guidelines had no such provisions.

Chapter 11 provides guidance on peer abuse, that is to say abuse of children by other children. The 1987 Guidelines contained no such provisions.

Chapter 12 deals with allegations of abuse against employees and volunteers. The 1987 Guidelines contained no such provisions.

[23] See pages 85-86 of Children First.
[24] See pages 87-88 of Children First.
[25] See page 89 of Children First at para. 9.11.4.

Chapters 13 and 14 concern supervision of staff involved in child protection work and training on child protection. Again, the 1987 Guidelines contained no such provisions.

Finally, **chapter 15** requires Health Boards to draw up local procedures to implement Children First. It also requires others to do so such as: hospitals, mental health services, education services, probation and welfare services, child care services, and voluntary and community groups. The local procedures must "adopt" chapters 3, 4 and 5 of Children First on definitions, reporting of child abuse and confidentiality. It is also required that local procedures "reference" chapters 6 to 12 and chapter 14, supplemented by information on procedures locally.

Local information would include details of training, the local approach to family support and clear descriptions of responsibility at local level of individuals and organisations. This again was an innovation. The 1987 Guidelines did not require local procedures.

CHAPTER III. STEPS TAKEN TO IMPLEMENT CHILDREN FIRST

Having outlined the requirements of Children First, this report now considers the steps taken to implement it.

(a) Up to 2002

Children First was launched on 21 September 1999. The Government decided that all Health Boards, government departments and organisations providing services to children should apply the Guidelines consistently. They were therefore printed and widely distributed.

A National Implementation Group was established. It was made up of representatives of each Health Board and one from the Department of Health and Children. It was later renamed the National Implementation Advisory Group to underline that it had an advisory and supportive nature, rather than an executive role. In other words, it was not the National Implementation Advisory Group's job actually to implement Children First. That was – and had to be – the role of the Health Boards.[26]

The National Implementation Advisory Group did not work alone. In late 2000 the Health Boards Executive Agency set up a Children First Resource Team to support the National Implementation Advisory Group. The Resource Team worked to develop solutions to difficulties thrown up by the process of implementing Children First.

The Health Boards Executive was a coordinating body for the Health Boards.[27] It provided a mechanism for them to work cooperatively on projects, but did not have any executive authority to oblige Health Boards to work together. It followed that the Resource Team, like the National Implementation Advisory Group, was advisory only.

The Department agreed the following priority items for implementation with the National Implementation Advisory Group -

- the appointment of an Implementation Support Person in each board to work with local management on implementing Children First;

- the appointment of a Training Resource Person to begin the process of internal training in each board;

[26] See in this regard Report on the Monitoring of the Implementation of Children First National Guidelines for the Protection and Welfare of Children, January 2003, Social Services Inspectorate, at p.14.

[27] See s.21 of the Health (Eastern Regional Health Authority) Act 1999. S.21, which established the Health Boards Executive, was only commenced in 2002. However, the Health Boards Executive existed on an ad hoc basis before that date.

- the appointment of an Information and Advice Person to deal with external organisations in each board, such as voluntary and community groups;

- the design and provision of training on the guidelines to all relevant staff in each board;

- the development of the Child Protection Notification System;

- the incorporation of the Minimum Data Set into all Management Systems;

- the commencement of Garda/Health Board cooperation;

- the commencement of the operation of Regional and Local Child Protection Committees.

Priority areas for implementation were reflected in the service plans of the Health Boards at this time.

As well as the Implementation Officers, the Training Officers and the Information and Advice Officers, sanction was given by the Department for the recruitment of social work team leaders in each community care area to facilitate the operation of the Garda/Health Board protocol as well as extra administrative support. This came on top of previous approval for the recruitment of a CCM in every community care area.

Another important step, taken by the Department of Health and Children, was the securing of funding for the appointment of an additional post for the Social Services Inspectorate (SSI). This enabled the SSI to begin monitoring the implementation of Children First.

Also in 2000 an Interdepartmental Monitoring Group was established. It involved a number of key departments involved in children's issues including the Departments of Education and Science, Justice Equality and Law Reform, Social Community and Family Affairs and, of course, the Department of Health and Children. Its remit included monitoring "progress in regard to the implementation of Children First in all organisations providing services to children" and "to provide a national forum for feedback with the Health Boards in implementing Children First." It had a particular role in relation to monitoring the rolling out of training, monitoring the preparation of local and sectoral guidelines, and receiving feedback from the Health Boards regarding progress on implementation.

It met initially for one year in 2000, but – as detailed below - was reconvened in 2003.

In 2002 the Department of Health and Children produced a document *Our Duty to Care*.[28] It was a guide for voluntary and community groups to assist them with implementing Children First and developing good child protection practice.

[28] Our Duty to Care, Department of Health and Children, 2002, http://www.dohc.ie/publications/our_duty_to_care.html, retrieved on 19 December 2009.

It has been suggested to this Office during an investigation meeting that there was no implementation plan for Children First. However, it is clear from the foregoing that planned steps were taken to implement Children First. It is also clear that those steps were substantial. The extent to which they were adequate is a matter considered further below.

(b) The Health Boards Executive evaluates implementation and clarifies Children First

A potential problem was that each of the Health Boards would implement Children First in different ways – and that some might not make the same effort to secure implementation as others. The creation of the Health Boards Executive Resource Team to help ensure common implementation was therefore an important step.

The Resource Team did an evaluation of the implementation of Children First throughout the Health Boards.[29] Its findings included that:

- Children First was the predominant source used for definitions of abuse, but not the only one;
- there were variations in practices on initial and full assessment;
- there was a lack of an out of hours service throughout the State, other than for homeless over 12 year olds in Dublin, Kildare and Wicklow;
- a large minority of community care areas were not holding strategy meetings (10 of 32, with a further 3 unclear whether they took place) and joint action sheets were being used in none of them;
- only 3 of the 32 community care areas had family support service plans in place;
- 3 of the 10 Health Boards had established Regional Child Protection Committees and 20 of the 32 areas had established Local Child Protection Committees;
- there was particular confusion regarding the operation of the Child Protection Notification System.

As already stated, Children First provides that the Child Protection Notification System "is a Health Board record of every child about whom, following a preliminary assessment, there is a child protection concern."[30] The Health Boards Executive Resource Team found considerable confusion among practitioners as to what this meant. 56% of Principal Social Workers and CCMs saw the Child Protection Notification System as a record of all children about whom there *is or has been* a child protection concern. 28% saw it as a record of

[29] See Report on Evaluation of Children First, the Health Boards Executive Children First Resource Team, 2002.
[30] See page 74 of Children First at para. 8.15.1.

children about whom there is a current or ongoing concern. 16% saw it as something other than these two.[31]

This was confusion on a fundamental issue. If it was a record of children about whom there was a current or ongoing concern, it was essentially a systems tool for managing cases by social work departments. If it also included children about whom there had previously been a child protection concern, it would have an enhanced value for outside professionals, who were meant to have 24 hour access to the Child Protection Notification System, so that they could check if the child had ever been at risk. Even if a child had been deemed - following an investigation by social workers of a report - not to be at risk, it would be useful for a doctor in an Accident and Emergency department of a hospital to know this if concerned about suspicious injuries to a child. It would also be useful for social work departments to know of the child having been in an Accident and Emergency department with suspicious injuries, so that they could reconsider the child's situation and the conclusions of any earlier investigation.

Children First's statement that the Child Protection Notification System was a record of every child about whom "there is a child protection concern" suggested that the Child Protection Notification System was to have the narrower role of a systems tool for social workers. However, the very fact that 24 hour external access was required, was consistent with the enhanced role outlined above.

The Health Boards Executive Resource Team worked to clarify this point. They drew up an Explanatory Guide to the Child Protection Notification System, which was published in December 2002.[32] It stated that the Child Protection Notification System -

> "should be interpreted as a narrow or restricted system which records only those cases where, following an initial assessment there are unresolved/ongoing child protection issues ... and as such excludes cases of child abuse where no ongoing active risk is suspected/established."[33]

It followed, according to the Health Boards Executive, that the Child Protection Notification System was "a systems management structure put in place by Health Boards to identify and monitor children in need of protection or at risk."[34] However, it also stated that it was not possible to delete a child's record from the Child Protection Notification System, but a case could be closed when the risk to the child was removed or reduced.[35] This meant that it would also have an enhanced value for those who were meant to access it from outside the social work department too – since historic cases would still show on Child Protection Notification System, but would be indicated to be closed.

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[31] See Report on the Monitoring of the Implementation of Children First National Guidelines for the Protection and Welfare of Children, January 2003, Social Services Inspectorate at p.10.
[32] See Report on the Monitoring of the Implementation of Children First National Guidelines for the Protection and Welfare of Children, January 2003, Social Services Inspectorate at p.10.
[33] Children First – Child Protection Notification System – Explanatory Guide, 2002. This was a joint publication of the 10 Health Boards.
[34] See the Explanatory Guide at p.13 at para 2.2.2.
[35] See the Explanatory Guide at p.13 at para 2.6.15.

The Explanatory Guide, in particular through a simple flow chart, brought clarity to Children First's assessment procedures more generally. Following the receipt of a report there was to be first of all *screening*, also known as a preliminary enquiry, to determine whether a report should or should not be actioned, and also to determine whether there was any immediate risk to a child.[36] It was at this stage that Garda notification was also to be first considered.

If the report needed to be actioned, an initial assessment was to be done. The Explanatory Guide was explicit that an initial assessment following screening would not be necessary in all cases.[37]

Following an initial assessment, a decision on notification was to be made. It was also clarified that it was the Child Protection Management Meeting that was to take the decision on whether to accept a notification onto the Child Protection Notification System, not the CCM.[38]

Like Children First, it emphasised that there needed to be 24 hour access to the Child Protection Notification System. But it did not say how that was to be ensured, especially in cases where the Child Protection Notification System was not computerised.

The Health Boards Executive also produced a second document, which explained the initial assessment process. Importantly, it clarified that an initial assessment had to be done for each child where more than one child was the subject of a report.[39]

These two Health Boards Executive documents were very important. Children First had not been as clearly drafted as it should have been on some issues, notably the Child Protection Notification System and initial assessment. The Health Boards Executive documents sought to prevent divergent practice throughout the State on issues of fundamental importance.

That said, there were areas where the Health Boards Executive documents added to confusion. Children First said that the CCM should refer notifications to an Garda Síochána. The Health Boards Executive stated that the Principal Social Worker should do this – and did not mention that Children First had stated otherwise.[40]

A bigger problem was that the Health Boards Executive documents had come late enough in the day. As one CCM interviewed by this office commented, many former Health Boards had already commenced implementation and were already operating their own procedures to give effect to Children First.

[36] See pages 7 to 8 of the Explanatory Guide at para 1.4.
[37] This was explicitly clarified at p.7 of the Explanatory Guide at para.1.4.1.
[38] See the diagram on page 5 of the Explanatory Guide and para 2.4.1 at p.11 and para.2.6.7 at p.12.
[39] See Children First, Initial Assessment, Form and Guidance, 2002 at p.3, section 1.
[40] See the Explanatory Guide at p.16 at para 3.1.2 and para 9.4.5 of Children First at p.86.

(c) The National Children's Advisory Council

The then Minister with responsibility for Children, Brian Lenihan TD, asked the National Children's Advisory Council to provide advice on the implementation of Children First on the ground. The Council duly reported in December 2002.[41]

The report was arrived at by consultation with groups and organisations involved or with an interest in child protection work through meetings and a questionnaire.

The report expressed concern that there did not appear to be "a coherent medium/long term strategy with year on year plans for the implementation review and monitoring" of Children First. It also found "differential compliance" among Health Boards and a lack of accountability for implementation.

In particular, it expressed concern that Regional Child Protection Committees had been established in only 2 out of 10 Health Boards. This impacted on the work of the Local Child Protection Committees since they were tasked to ensure that policies and procedures devised by the Regional Committees were implemented. It recommended that this be raised with the Interdepartmental group or departments.

It also expressed concern that there was no plan for SSI to continue to inspect child protection work beyond the report which it was subsequently to produce in January 2003 (discussed below). It recommended that agreed arrangements be developed for internal evaluation and external inspection. This included agreed standards being set by SSI and rolling inspections being set. Shortcomings should then be addressed through agreed action plans.

It also recommended that rather than standing down the National Implementation Advisory Group, consideration should be given to extending its remit to include drawing up a strategic plan to achieve full implementation.

These were important recommendations. In particular, the recommendation for the setting of standards, inspection on those standards by SSI and then the agreeing of action plans to identify shortcomings would have helped to ensure that Children First was delivered on the ground. That recommendation was not implemented.

(d) An industrial relations issue arises in the Eastern Regional Health Authority region

A particular difficulty arose with the implementation of Children First in the former Eastern Regional Health Authority region. The Eastern Regional Health Authority comprised all of counties Dublin, Kildare and Wicklow.[42] Eastern Regional Health Authority was, in turn,

[41] National Children's Advisory Council, Advice to the Minister on Implementation of Children First and Vetting, December 2002.
[42] See s.7(4) of the Health (Eastern Regional Health Authority) Act 1999.

divided into three area Health Boards, the Northern Area Health Board, the East Coast Area Health Board and the South Western Area Health Board.[43]

This Office became aware of an industrial relations issue regarding the implementation of Children First in the course of this investigation. In order to gain a better understanding of the issue, as well as to hear wider views on the implementation of Children First, the Office sought a meeting with IMPACT trade union.

IMPACT stated that in 2001 there had been a particular difficulty in the former Eastern Regional Health Authority region due to a shortage of social workers and a lack of administrative support. Staff were concerned that they were spending time doing administrative work and attending court when they did not have enough numbers to provide a "life and limb" service.

IMPACT entered into negotiations with Eastern Regional Health Authority management. This resulted in an agreement being reached between IMPACT and the Eastern Regional Health Authority, which was known as the "prioritisation of work agreement." It was set out in a letter from the Eastern Regional Health Authority Employee Relations Manager dated 2 June 2002, but in fact from 2 July 2002, which was supplied by IMPACT to this Office.

The prioritisation of work agreement applied to the Eastern Regional Health Authority region, which contained over one third of the State's population.[44] It identified the following priorities:

- **Child Protection** – it specified that emergency cases would be responded to on the day of referral. Cases that were serious but not presenting an immediate risk "should be responded to within a specified period of time", which was not specified;
- **Children in the care of the board**;
- **Children who were the subject of court proceedings**;
- **Promoting the welfare of children** (adoption services, fostering enquiries, community development).

The prioritisation of work agreement also dealt with such matters as who should attend court and "the need for social workers to concentrate on their core activities and to devolve non-core activities." To this end, it was agreed that greater clerical support would be provided. IMPACT stated that this never materialised.

IMPACT advised that the aim of the prioritisation of work agreement was to assist social workers. Before this, they stated, Principal Social Workers did not have autonomy to prioritise work on the basis of need. The agreement gave Principal Social Workers this power.

[43] See s.14 of the Health (Eastern Regional Health Authority) Act 1999.
[44] See Central Statistics Office, Population of each Province, County and City, 2006, available at http://www.cso.ie/statistics/popofeachprovcountycity2006.htm, retrieved on 29 December 2009.

Nowhere in the prioritisation of work agreement was Children First mentioned, although – as stated above – child protection was mentioned. IMPACT gave its view in relation to the handling of Children First in the negotiations. "It was accepted by Management and IMPACT that Children First was not a priority", an IMPACT negotiator stated. At the same time, IMPACT also asserted that this had not undermined Children First.

IMPACT advised that the prioritisation of work agreement was still operational in that there was no new agreement and that there had been no engagement on the management side since 2004. As to what this meant in reality, IMPACT advised that while in theory Children First was implemented, the form filling envisaged by Children First, mainly around initial assessment, was not completed. Garda notification forms were also not filled out. Social workers did, by contrast, engage in Children First training. It was further clarified that there were two areas of the Eastern Regional Health Authority where Children First was fully implemented because resources had been made available.

IMPACT also stated that "there is no live instruction from IMPACT to social workers not to implement Children First."

However, in written correspondence and interviews with managers in the Eastern Regional Health Authority region, the following was stated:

- A manager stated that while HSE management would say that it was not a live issue, the local union representative would feel that the industrial relations issue was still in place. The manager would not be confident to call practice Children First as there might be a reaction to this.
- A second manager stated that as a result of the trade union agreement, the manager's area would not say that they were implementing Children First. That manager did not know what steps were taken by the HSE to resolve the union matters, but stated that they were not resolved.
- A third manager stated that "there was a union directive that until Children First is properly resourced it is not going to be implemented." The manager added nonetheless that a child protection service was still being provided. Some areas had followed the union directive but others had developed guidelines along the lines of Children First but were not defining it as Children First.
- A fourth manager stated that there had been an agreement between the Eastern Regional Health Authority and IMPACT trade union and that -

  > "arising from this an instruction was issued to all social workers and managers that Children First would not be implemented without adequate resourcing and the agreement remains in place to the present day."

  That manager also stated:

  > "Children First is not implemented in [this] local health office... There remains continuing staffing implications together with remaining unresolved industrial relations issues which continue to compromise implementation."

- A fifth manager stated that there was an agreement that –

> "covered the former Eastern Regional Health Authority and community care areas 1, 2, 3, 4, 5, 6, 7 and 8 due to those areas not having adequate resources in the social work departments at that time. Implementation of Children First in the future in any of those areas would involve re-negotiation with IMPACT. This agreement was reached at a high level in the then regional structure. There have been no known approaches to renegotiate the position either regionally or locally in the HSE's structure."

This Office requested any written evidence regarding IMPACT's stance. As a result, a copy of an email was provided, which was written by an IMPACT representative. This Office is satisfied that the representative was familiar with the trade union's position. The email stated:

> "To your enquiry about implementation of Children First.
>
> There was an agreement made between IMPACT and the former Eastern Regional Health Authority that community care areas 1, 3, 4, 5, 6, 7 and 8 would not implement Children First due to not having adequate resources in the social work departments of the time. This went on to say that if an area wished to implement Children First in the future that they would have to renegotiate with IMPACT Union for implementation.
>
> I hope this helps to clarify the issue for you"

The email was dated **12 August 2009** and this Office understands that it was not in response to a request for the historic position of the union, but the current one.

The above statements from managers and the union representative were put to IMPACT by this Office in writing in February 2010. It responded:

> "In respect of the Prioritisation Agreement, it was agreed between IMPACT and the Eastern Regional Health Authority that, because of critically low numbers of child protection Social Workers employed, the administrative implications of the Children First Guidelines would not be performed by Social Workers. In the absence of any approach by management on this issue, the union position is that this situation has not changed."

The above statements from managers and the union representative were also put to the HSE at the same time. It denied that there was any agreement not to implement Children First. It pointed out that the prioritisation of work agreement listed child protection as the first priority. "Implicit in this was that this would be achieved by whatever means possible, including Children First where applicable," the HSE added.

This Office has considered these conflicting accounts of the meaning and effect of the prioritisation of work agreement and concludes as follows, based on the evidence provided:

First, an important context of the negotiations was that IMPACT objected to the administrative aspects of Children First. This must have been known to Eastern Regional Health Authority.

Second, the prioritisation of work agreement never once mentioned Children First. Rather it only mentioned child protection.

Third, by mentioning only child protection, and not Children First, it was obvious that IMPACT would take from the agreement at least that administrative aspects of Children First did not have to be performed. This also left the overall status of Children First uncertain.

Fourth, IMPACT did in fact take from the agreement that administrative aspects of Children First did not have to be performed. And, as can be seen from the quotes from managers above, the overall status of Children First did become uncertain.

Fifth, if the Eastern Regional Health Authority did not realise this when they were concluding the prioritisation of work agreement, they most certainly ought to have. And they were certainly aware after the agreement was concluded that this had been how it had been interpreted by IMPACT.

The position arrived at was one where it was obvious that each side would walk away with the interpretation that suited it. The Eastern Regional Health Authority – and later the HSE – could deny that it had agreed to the non-implementation of Children First's administrative aspects. But IMPACT could equally claim that the Eastern Regional Health Authority – and later the HSE – had agreed to the non-implementation of Children First's administrative aspects. By failing to be clear on this, uncertainty hung not only over the administrative aspects of Children First, but Children First more generally. This uncertainty did not serve the best interests of children.

What the practical effects of the Agreement were in practice is considered further in Chapter IV of this report.

(e) The report of the Social Services Inspectorate 2003

As already indicated, a dedicated Social Services Inspector was appointed to inspect the implementation of Children First. This was stated by the then Minister for Health to be for an initial three year period.[45] The SSI published a short report on the implementation of Children First in January 2003.[46] It provides an overview of where implementation had

[45] See the remarks of then Minister for Health and Children Michael Martin TD at the Joint Committee for Health and Children on 20 June 2000, available at http://www.gov.ie/committees-00/c-health/000620/default.htm, accessed on 29 December 2009.
[46] Report on the Monitoring of the Implementation of Children First National Guidelines for the Protection and Welfare of Children, January 2003, Social Services Inspectorate.

happened, and where it had not. The report was based on interviews with stakeholders and a questionnaire sent to Health Boards.

The report concluded that the strategy for implementation had been a success. The Inspector gave the example of the difficulties that had been encountered with the Child Protection Notification System and how a national solution had been found by the Health Boards Executive instead of each of the ten Health Boards developing their own one.[47] But the Inspector also found that there had been difficulties with implementation.

Among the finding of the report was:

- that distribution of the guidelines had been completed in seven of the ten Health Boards by the end of 2001;

- Health Boards, especially in the Dublin area, had experienced considerable difficulty in recruiting people to fill the Implementation Officer posts, Training Officer posts and Advice and Information Officer posts. This had, for example, impacted on their ability to provide advice and support to voluntary groups;

- While all boards had trained their staff, some had trained a far greater number of staff than others and had offered a greater variety of training;

- Only one Health Board had established Garda/Health Board liaison management teams by the end of 2001. Many Health Boards still had informal arrangements, but they tended to depend on personal contacts, which was a cause of concern;

- Only three boards were operating the notification system envisaged in Children First. Five boards were operating other notification systems that they had developed before Children First.

- By the end of 2001, Local Child Protection Committees had been established in eight Health Boards. Only three Health Boards had established Regional Child Protection Committees. There had been a particular difficulty securing the attendance of officials of the Department of Social Community and Family Affairs and the Probation and Welfare Service. There was also a difficulty with the attendance of schools and medical practitioners, since schools and medical practitioners acted independently of each other.

- Only two boards had family support service plans in place by the end of 2001.

While the work of the Health Boards Executive resource team had been a success, the report concluded that implementation of Children First had not been complete.[48]

[47] See the Report at page 3.
[48] Report on the Monitoring of the Implementation of Children First National Guidelines for the Protection and Welfare of Children, January 2003, Social Services Inspectorate at p.13.

Critically, the Report expressed concern that "both the National Implementation Advisory Group and the Health Boards Executive Resource Team are to be disbanded in early 2003, leaving no national infrastructure for the development of solutions to outstanding difficulties."[49]

That disbandment nonetheless went ahead and SSI ceased thereafter to monitor the implementation of Children First. However, the Health Boards Executive agreed to a "Conjoint Programme of Action for Children" which was to ensure that the outstanding issues relating to Children First were addressed.

This Office asked the OMCYA why it was that inspection had ceased in 2003. The response was:

> "The final report [of SSI] was published in 2003, at which point the former Health Board Executive Agency had been established. One of the Health Boards Executive's tasks was to coordinate the further implementation of Children First. Given that the Health Boards Executive was undertaking this role it was considered that there was little more that the SSI could contribute to this process. Following a decision made by the Chief Inspector of SSI in consultation with the SSI Steering Committee, the SSI has not engaged since then in any further Children First related activities."

This Office has concerns at the statement that the Health Boards Executive was undertaking "this role." The role that the Health Boards Executive was undertaking was coordinating implementation. That is not the same as external inspection. Further, the role of the Health Boards Executive was scaled back, with the Health Boards Executive Resource Team disbanded at the end of 2002.

More importantly, this Office cannot agree with the conclusion that there was little more that SSI could contribute to the process. Inspection of child protection services is important in order to assess what the true state of service delivery is on the ground. It is particularly important at a time when reforms are being delivered since it not only checks what has been achieved, but also what reforms are outstanding. That way it provides an impetus to complete the reform process. An excellent example of this was the role of the Oversight Commissioner during the implementation of the Patten report on policing in Northern Ireland.[50]

Given –

- the nature of the reforms contained in Children First,
- the importance of child protection work and its complexity, and
- the real and important areas where implementation was clearly deficient,

[49] Report on the Monitoring of the Implementation of Children First National Guidelines for the Protection and Welfare of Children, January 2003, Social Services Inspectorate at p.4
[50] As to which see http://www.oversightcommissioner.org/, retrieved on 15 January 2010.

continued external inspection, followed up by action plans to remedy shortcomings, would have been highly desirable – and its absence considerably weakened the implementation process.

In later correspondence, OMCYA pointed to other priorities for inspection, including children's residential care and foster care. This Office agrees that these were important areas, but cannot agree that inspection of child protection should have ceased as a result.

It is notable that in Northern Ireland, Scotland, Wales and England, those responsible for the delivery of child protection are subject to regular external inspection.[51] In Northern Ireland, this is delivered through the Office of Social Services, a professional body within the Department of Health, Social Services and Public Safety, and detailed inspections have occurred against agreed standards which have highlighted important shortcomings in the child protection system there.[52]

The Ryan report implementation plan states that SSI will develop standards regarding child protection by February 2011 and commence inspection against those standards by September 2011.[53] That is a positive development. But it would have been far better in the circumstances had inspection of child protection not ceased.

Before arriving at any further conclusions regarding the decision to withdraw external inspection, it is important to consider what further efforts were made at implementation and what internal auditing of Children First's implementation there was. It is only in that context that a fair judgment can be arrived at on the implementation of Children First.

(f) The Conjoint Programme of Action

Following the disbandment of the Health Boards Executive Resource Team, the Health Boards Executive's Programme of Conjoint Action for Children assumed responsibility for coordinating the implementation of Children First.

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[51] In England inspection is now performed by the Office for Standards in Education Children's Services and Skills, established under Part 8 of the Education and Inspections Act 2006. See www.ofsted.gov.uk, retrieved on 15 January 2009. In Scotland inspection is carried out by Her Majesty's Inspectorate of Education in Scotland and the Social Work Inspection Agency under the Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act 2006, see www.hmie.gov.uk and www.swia.gov.uk, retrieved on 15 January 2009. In Wales inspection is carried out by the Care and Social Services Inspectorate Wales under Health and Social Care (Community Health and Standards) Act 2003.

[52] See Our Children and Young People – Our Shared Responsibility, Inspection of Child Protection Services in Northern Ireland, Overview report, December 2006, Social Services Inspectorate, available at http://www.dhsspsni.gov.uk/oss-child-protection-overview.pdf, retrieved on 22 December 2009.

[53] See Action 42 of the Ryan Report Implementation Plan, OMCYA, July 2009, available at http://www.omc.gov.ie/viewdoc.asp?fn=/documents/Publications/Implementation_Plan_from_Ryan_Commission_Report.pdf, retrieved on 15 January 2010.

But there is little evidence that continuing problems with the implementation of Children First were successfully addressed. This is not to say that some useful work did not emerge from that programme. To the contrary, it led to the establishment of the National Child Care Information System Project in March 2004 which, as its name suggests, aims to develop a single information system in the field of child care.

The Conjoint Programme of Action also led to the decision to conduct a national review of Children First. This was the OMCYA review, discussed below.

It also led to the conducting of a number of focus groups. But this work did not emerge until after the creation of the HSE – and is also discussed further below.

(g) The Interdepartmental group reconvenes

Following on from the National Children's Advisory Council report and the SSI report, in May 2003 the Interdepartmental Group was reconvened. In all, it met on five occasions. A questionnaire was sent out to Health Boards by the Group asking about the problems being encountered with Children First's implementation.

Responses from the Health Boards were circulated to members of the Interdepartmental group at the fourth meeting in November 2003 and departments were asked to see if issues relating to their departments could be resolved. The responses were also compiled in a memorandum produced in December 2003. This information in this memorandum was not published, but was obtained in the course of this investigation. While facts and figures differed, the overall picture was consistent with what SSI had uncovered. The following is a summary of the findings:

- **Regional Child Protection Committees:** Four (out of 10) Health Boards had not established Regional Child Protection Committees. The Northern Area Health Board Regional Child Protection Committee, which covered north county Dublin, was suspended due to industrial relations problems. All those Regional Child Protection Committees that had been established reported problems with attendance to some degree.

- **Local Child Protection Committees:** 2 Boards had not established any Local Child Protection Committees. 7 averted to attendance problems. The South Western Area Health Board, comprising most of South County Dublin (but not Dun Laoghaire or Dublin South East), Kildare and a small part of Wicklow, indicated that the lack of agreement regarding implementation of Children First had resulted in the social work service declining to become involved in the Committee.

- **Garda/Health Board cooperation:** 5 Health Boards did not have a protocol in operation with an Garda Síochána. Staff turnover was also cited as a problem impeding joint working. Joint action sheets were not in use even in areas with a protocol. The South Western Area Health Board indicated that "until there is

agreement with IMPACT regarding the full implementation of Children First, it will be difficult to ensure the protocols are implemented."

- **Child Protection Notification System:** Northern Area Health Board and South Western Area Health Board both reported difficulties due to industrial relations which meant that the Child Protection Notification System was not in place in some areas.

- **Other issues:** Among the other issues raised were - the need for further guidance on underage pregnancy; insufficient social worker numbers; the need to get good quality child protection practice across the wider health service; the need to improve family support services; the need for out of hours services; a lack of correspondence between Garda and Health Board geographical boundaries; and a lack of information sharing between disciplines.

Following on from this in March 2004 the Interdepartmental Group met again. This was the fifth meeting of the group. At that meeting, it was indicated that the department was tendering for the evaluation of Children First. Departments were asked again to follow up with any difficulties that the Health Boards may be having with them. They were also asked to check that all services for children funded by them complied with Children First.

However, there is no evidence of the issues identified by the report to the Interdepartmental Group actually having been dealt with. This Office therefore asked OMCYA about the situation after March 2004. It responded that it had been intended for the Interdepartmental group to meet again in October 2004, but this did not happen. OMCYA explained that this was because the relevant officials were tasked with the discovery of documents for the Laffoy/Ryan Commission and preparation for the Department's statement and witness appearances at the Commission in 2004. This impacted on the ability of the officials to hold a further meeting of the monitoring group.

Separately, OMCYA also pointed out that its Child Care Unit met regularly with individual Health Boards in service planning meetings where children's issues were discussed. However, while this was useful, it is clear that the same problems remained - as Chapter IV of this report demonstrates.

OMCYA also pointed out that the creation of the HSE on 1 January 2005, discussed below, "provided the necessary framework to ensure that national policies and guidelines were uniformly implemented", although it added that the Department of Health and Children continued to have an overseeing role in respect of the Guidelines. It commented also that in 2005 the Minister of Children announced a review of compliance with the Guidelines.

While this Office accepts that the HSE supplied a vehicle for ensuring consistent national implementation within the health sector, it remained important to ensure consistent implementation across sectors. The failure of the Interdepartmental Committee to meet after March 2004 compromised this.

(h) The formation of the HSE

The creation of the Health Boards Executive marked a step towards greater coordination between Health Boards. It had been provided for by the Health (Eastern Regional Health Authority) Act 1999 and formally came into existence in 2002, although it existed on an ad hoc basis for some time before then.[54]

However, Irish health services underwent a far more radical restructuring with the abolition of the Health Boards and the creation on 1 January 2005 of the Health Service Executive.[55]

Under s.59 of the Health Act 2004, the functions of the Health Boards became functions of the Health Service Executive. This had obvious implications for Children First, since it required Health Boards to do certain things, like draw up local procedures implementing Children First. These were now the tasks of the HSE.

At the same time, Children First clearly envisaged that some things be done at local level, such as the drawing up of local procedures with descriptions of local responsibility for child protection, details of local training, details of the local approach to family support etc. It was important, therefore, to know to whom within the HSE responsibility for these local functions was delegated.

This Office therefore asked the HSE for documents detailing where the Health Boards' responsibility for Children First now lay within the HSE. This was particularly relevant since, as detailed in Chapter IV below, many Local Health Offices around the State had drawn up local procedures, while others had not. But Local Health Office management could not be expected to have such procedures without it being clear that this responsibility was delegated to them.

Some documentation was received in response to the request for evidence of delegation. But none of the materials supplied were, in fact, relevant to the request.[56] However, the HSE subsequently advised that Local Health Managers had responsibility in this regard. This Office asked for a copy of any instruction issued in this regard. The HSE responded that no specific instruction issued to Local Health Managers but that every Local Health Manager was aware that responsibilities were delegated to them.

In the absence of any instruction, specific or general, to Local Health Managers that it was their responsibility to ensure that local procedures were drawn up, this Office – as a matter of fairness – does not make any adverse finding against them where this was not done. That said, areas without local procedures ought to have been aware that other areas had drawn them up.

[54] See s.21 of the 1999 Act.
[55] See the Health Act 2004 and the Health Act 2004 (Establishment day) Order 2004 (SI 885 of 2004).
[56] The documents received related to the delegation of specific functions under the Child Care Act 1991 and related legislation (but not the general function of the HSE under s.3 of that Act).

(i) The HSE considers the implementation of Children First

Materials supplied by the HSE to this office show that it conducted two reviews of the implementation of Children First.

The first was *Findings from the National Focus Groups on Current Practice and Opportunities for Change.* This was an initiative of the Conjoint Programme of Action for Children, but was undertaken by the HSE upon its creation.[57] The report simply reflected a number of focus groups of senior social work practitioners and managers in May 2005. It expressed concern regarding fundamental issues such as –

- the implications of Garda notifications for social work departments,
- the need for clarification of initial and full assessment processes,
- the role of strategy meetings and case conferences,
- the lack of use of the Child Protection Notification System by agencies to inform themselves if a child is known to social work departments, and
- the need for national standards for child protection and quality assurance.

The second report emerged from work undertaken following the publication of the *Ferns Report* in October 2005.[58] The HSE established a number of task groups to take forward implementation of the report's recommendations. HSE Project Task Group 3 was charged with reviewing the implications of the Inquiry's recommendations for HSE child protection and welfare practices and to make recommendations. Unlike other reviews, the report of Task Group 3 did not conduct any survey or research into the implementation of Children First. But it did comment upon it – and make recommendations. Included among these was the observation that it was not clear that all Health Boards had produced local procedures but that –

> "in view of the amount of work that this will entail, it might be prudent to wait to see what is the outcome of the current ... review of Children First"[59]

It also admitted that the structures envisaged by Children First had not been built, or if built had not been sustained"[60] and that it was difficult in practice to get stable working relationships between an Garda Síochána and the HSE due to, for example, staff turnover, shift working and the absence of an out of hours service.[61] It made 29 recommendations, including –

[57] Dr Henri Giller and John Smyth, Children First: Findings from the National Focus Groups on Current Practice and Opportunities for Change (2005).
[58] Report of the Ferns Inquiry chaired by Judge Frank Murphy, assisted by Dr Larraine Joyce and Dr Helen Buckley, 25 October 2005.
[59] See Report of HSE Project Task Group 3, Ferns Inquiry Report, 2006, at page 11.
[60] See Report of HSE Project Task Group 3, Ferns Inquiry Report, 2006, at page 22.
[61] See Report of HSE Project Task Group 3, Ferns Inquiry Report, 2006, at page 33.

- the development of child protection units of social workers and Gardaí similar to those in the UK,

- the development of an out of hours service,

- a national standing group of the HSE and Garda Síochána to oversee the implementation of Children First, and

- action by the HSE to address inconsistency of implementation of Children First across Local Health Offices.

(j) Former Southern Health Board (Cork/Kerry) audits itself 2003-2004

In the absence of any system of inspection from 2003 on, Local Health Offices in Cork and Kerry, all formerly part of the Southern Health Board, decided themselves to audit their practices. This audit was on cases reported between 2003 and 2004 and its results were published in 2006.

This was an extremely valuable initiative, and was conducted in a region that this Office is satisfied was proactive in its attempts to implement Children First.

Unlike the reviews described above, and indeed those subsequently undertaken - described in the sections that follow - this audit was not confined to meetings and questionnaires. Instead, it involved a thorough examination of how reports raising child protection concerns had been handled in practice.

Its results were worrying. It revealed that there were gaps between standards and practice:

- It noted that screening and assessment processes needed to be aligned in Social Work Departments. Only 1 in 5 of the departments surveyed was regarded as a "functional area of the health service" after completion of the Audit. The main problems identified were that social workers were not seeing or interviewing children in the course of their investigations (this was despite the fact that local policy stated that social worker will need to "physically see the child"), or no record of same, bad case management and lack of consistency across departments.

- The audit revealed that 75% of files had no record of the outcome of an assessment. By contrast, Children First requires that outcomes always be recorded.[62]

- The standard time scales for screening and initial assessment were long. The mean reported screening time was 21 days. The mean time for initial assessment was 95 days. Of course, Children First did not establish actual targets for screening and initial assessment. But if screening was to take an average of 21 days, it meant that

[62] See Children First at page 78, para. 8.18.8. One of the possible outcomes is, of course, "inconclusive."

there would be a delay in identifying cases where urgent action was required. That, in turn, could prejudice the safety of children and is inconsistent with the requirement in Children First that "where safety and welfare [of a child] are at risk, the concern must be followed up immediately."[63]

- In fact, only 18% of screening was carried out within one day and only 4% of initial assessments were carried out within 8 days.

- Consulting with parents and consulting with professionals was reported as high, but feedback to those who had made the report to the social work department was low, especially where the reporter was a family member or a neighbour rather than a professional.

- As regards standardisation of practice, the results indicated that the maintenance of records was not standardised across social work departments. There was a variance between departments in recording such basic information as the child's age and nationality. 1.3% of cases did not record the child's name. 33% of cases did not record the child's date of birth.

- The auditors who carried out the research noted that there was significant divergence of practice between the work in their own departments and that of the department they were auditing. This was despite the fact that all were operating from the same guidelines – as they were all part of the former Southern Health Board.

Subsequent action was taken by Cork and Kerry to address some of these concerns.

It is no surprise to this Office that the audit that uncovered the most significant and, indeed, startling results, was the audit which involved analysis of individual case files. The results of the Cork/Kerry audit also highlight why actual inspection of files around the State was highly desirable and why the SSI inspector post dedicated to Children First should have continued.

Further, the audit uncovered serious problems not with the more elaborate aspects of Children First, but rather very basic ones. Without such auditing or inspection being conducted more generally throughout the State there is the real danger of misdirection, with efforts being made to achieve advanced standards of implementation when fundamental issues are not addressed. Such misdirection would itself hinder the implementation of Children First.

No evidence has been provided to this Office of audits of casefiles having been conducted since in the Cork/Kerry area – or elsewhere.

[63] See Children First at pages 69 and 70, paras 8.7.4 and 8.9.

(k) OMCYA review of Children First 2005-2008

Following the publication of the Ferns report in October 2005, the then Minister for Children Brian Lenihan TD announced a "national review of compliance with the Children First guidelines" adding that it was "essential that the Government can stand over its own procedures in protecting children."[64] This led to the publication of three documents:

- an analysis of submissions to the review;
- a survey of service users; and
- the findings of the national review.

Unlike the Cork/Kerry audit, this review did not involve an audit of implementation on the ground, but rather an analysis of submissions received from the public and from key stakeholders based on a questionnaire sent to them.

136 submissions were received. Those submissions were not published (although they were sought and received by this Office in the context of this investigation). What was published instead was an *analysis of submissions* made.[65] The analysis of the submissions concluded that consultees in the main held the view that the Children First guidelines were "with a small number of exceptions, generally adequate." But there were "many difficulties arising from a failure to implement the Children First guidelines in a consistent way throughout the State, particularly in the areas of support services and structures, training, point of referral and communication." It was also suggested that in the absence of a framework for evaluating the implementation of the guidelines, these inconsistencies would continue to arise.

A *survey of service users of the child protection system* was also conducted.[66] Its findings often related more to the overall experience of the child protection system of service users than the specific implementation of Children First. Among the concerns raised were the intimidating nature of the service, difficulty accessing the service – and social workers in times of need, lack of familiarity with its procedures and, in some cases, a concern regarding delay. There was also a lack of active participation of service users in the development of child protection plans, but service users said that they were clear about what was required of them and there was much evidence that parents were being routinely involved in child protection conferences.

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[64] See National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children, OMCYA, July 2008, at page 1.

[65] See Analysis of submissions made on national review of compliance with Children First: National Guidelines for the Protection and Welfare of Children, OMCYA 2008, at http://www.omc.gov.ie/viewtxt.asp?DocID=877&StartDate=01+January+2009, retrieved on 27 December 2009

[66] Buckley, H., Whelan, S., Carr, N. and Murphy, C. (2008) Service users' perceptions of the Irish Child Protection System, Office of the Minister for Children and Youth Affairs. Dublin: The Stationery Office.

Finally, the *review* itself was published in July 2008. The key finding of the review was that "difficulties and variations in relation to implementation of the guidelines arise as a result of local variation and infrastructural issues, rather than from fundamental difficulties with the guidelines themselves."[67] Consistency of implementation and the development of standards was therefore to be given priority.

Among the review's findings was that the initial impetus for implementing Children First had lost momentum, that information sharing was not happening as envisaged, that the Child Protection Notification System was not accessible outside the child protection service and that the regional and local child protection committees were not working effectively. A fuller summary of the key findings of the Review is provided at **Annex C**.

In outline, it recommended:

- that effective child protection procedures and training be put in place, implemented and regularly reviewed in all settings where services and activities are provided for children and that direct and indirect funding from government be made contingent on same;

- that measures be taken to reduce the risk of child abusers reoffending;

- that persons seeking to raise a child welfare or protection issue in respect of a child be facilitated to do so;

- that the Children First guidelines be applied in a consistent manner across the HSE and that the HSE develop good practice guidelines underpinned by appropriate management and quality assurance;

- that early intervention and family support services be strengthened and that child welfare and protection factors be taken fully into account when prioritising access to other health services;

- that the HSE reviews and replaces, if necessary, the current local and regional child protection committee structure and puts in place an appropriate structure to facilitate effective child protection across the HSE.

These recommendations were worthwhile. And the findings reproduced at **Annex C** appear correct – and tally with many of the findings of this investigation at Chapter IV below.

But the findings of the Review are not complete.

This Office sought the submissions made to the OMCYA review. Overall, the issues raised by those who made submissions were reflected in the Review report or, at least, the published analysis of submissions. There was, however, one significant exception.

[67] At p.3.

Some of those who made submissions raised the industrial relations dispute in the Eastern Regional Health Authority region. The following was stated:

> "Children First has not been implemented in [a Dublin area] due to union issues, whereby the Social Work Team sought support from the Union re non-implementation until such time as posts (vacancies) were filled and waiting lists addressed."
>
> "In the HSE Dublin Mid Leinster region the spirit of Children First is adhered to but the document has not been formally implemented, due to IR issues which have remained unresolved."
>
> "Union Embargo – allowed lack of action in implementing. Position has been allowed to drift."
>
> "The IR issues in relation to this locally can lead to confusion for organisations whose expectations are based on the full implementation of Children First."

These comments came from:

- a Principal Social Worker;
- Four Child Care Managers;
- a Children First Implementation Committee, including a Principal Social Worker, a Child Care Manager, a Social Work Team Leader, a Training Officer and an Information and Advice Officer; and
- a Children First training team in Dublin Mid-Leinster.

All were professionals in the field who had knowledge of the situation in the former Eastern Regional Health Authority region. Nowhere, however, in the OMCYA review – or even in the analysis of submissions - was this referred to, nor yet was there any indication of what efforts had been made or would be made to overcome these problems. Yet it is clear, not least from the comments above, that this was a substantial difficulty in the implementation of Children First in most of the former Eastern Regional Health Authority region.

However, the concern that implementation was allowed to drift does not appear to have been caused by the industrial relations in the Eastern Regional Health Authority region alone. An even greater problem appears to have been a general lack of drive to implement Children First at national level.

This is evidenced by the recommendations and findings of the OMCYA review itself. Previous reviews (e.g. the SSI report and the survey of the Interdepartmental group) had already identified many of the problems found by the OMCYA review such as inconsistent implementation, regional and local committees not meeting and the failure to structure Garda/HSE cooperation as required by Children First. While the OMCYA review was worthwhile, it was no substitute for implementation. It was important that – in parallel – efforts to drive implementation proceeded. This was especially so when the review took almost three years to complete.

However, instead of keeping pace, there is evidence that efforts to ensure implementation lost momentum. The fact that the OMCYA review identified many of the same issues as previous reviews and inspections itself indicates this. Also, as already seen, the Interdepartmental Group reconvened in 2003, but ceased to meet again in 2004 – despite the range of implementation problems identified by the survey and without, it appears, having addressed these successfully. Separately, as will be seen later in this report, some Local Health Offices – such as **Wicklow** and **Dublin West** - did not develop either any or full local procedures because the OMCYA review was ongoing. A HSE official in a meeting with the OMCYA in 2006 even went so far as to suggest that that the OMCYA review had led to "a lack of respect for Children First."

In short, the almost three year OMCYA review was useful. But work needed to continue in parallel to drive implementation forward. This Office does not believe that sufficient efforts were made in this regard.

(l) The High Level Group meets – for a limited period

The submissions to the OMCYA review revealed a large range of other issues where there were problems with Children First.

For example:

- there were real concerns around information sharing, with – for example – one medical consultant indicating to a social worker that he would be guided by data protection legislation rather than Children First;
- problems were identified with Garda cooperation, including failure to use joint action sheets and failure to establish the liaison arrangements envisaged by Children First;
- concern was expressed at a lack of guidance on underage pregnancy;
- concern was expressed at a lack of guidance on the High Court case *MQ v Gleeson,* which set out the procedures necessary for the sharing of soft information.[68]

These are some of the areas where further guidance would have been useful.

According to the OMCYA review, the OMCYA was to be responsible for:

- convening meetings between relevant parties from time to time;
- identifying any problems or shared learnings;
- keeping under review the effectiveness of the Children First national guidelines.

[68] [1998] 4 IR 85.

The OMCYA review stated that the High Level group established following the *Review Inquiry on any Matter pertaining to Child Protection Issues touching on or concerning Dr A* ("the High Level Group") provided "an ideal mechanism to jointly consider issues arising from this review or any other relevant child welfare and protection issues."[69] In short, it would undertake this work.

This Office sought the minutes of that group. It met six times in 2008 and discussed some important issues such as mandatory reporting, joint action sheets the development of an audit framework and child protection in schools. But many of the other cross-cutting issues identified in the OMCYA submissions were not discussed.

Further, no meetings took place in 2009. OMCYA explained that a decision was taken that the group would be reconvened when the revised Children First Guidelines were published and disseminated. However, this Office believes that there were many important issues that could have been clarified, and which were not dependent on the publication of the revised Children First Guidelines – such as the provision of guidance on the implications of *MQ v Gleeson* and guidance on information sharing and data protection legislation.

This Office concludes that despite initial progress, the focus on cross cutting implementation was again lost. As it was the responsibility of the OMCYA to convene these meetings, the failure to continue to convene them must also be the responsibility of the OMCYA.

Separately, as already stated, the OMCYA in its implementation plan in response to the Ryan Report has committed that the SSI will resume inspection of child protection by September 2011.[70] The implementation plan also contains other commitments that should advance the implementation of Children First, including the following:

- Compliance with Children First will be linked to all inspection processes across the education, health and justice sectors.[71]
- All staff employed by the State and in agencies in receipt of funding by the Exchequer are to be obliged in new legislation to comply with Children First and to share information in the best interests of the child.[72]

[69] See National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children, OMCYA, July 2008, at page 18.
[70] See Action 42 of the Ryan Report Implementation Plan, OMCYA, July 2009, available at http://www.omc.gov.ie/viewdoc.asp?fn=/documents/Publications/Implementation_Plan_from_Ryan_Commission_Report.pdf, retrieved on 15 January 2010.
[71] See Action 88 of the Ryan Report Implementation Plan, OMCYA, July 2009, available at http://www.omc.gov.ie/viewdoc.asp?fn=/documents/Publications/Implementation_Plan_from_Ryan_Commission_Report.pdf, retrieved on 15 January 2010.
[72] See Action 85 of the Ryan Report Implementation Plan, OMCYA, July 2009, available at http://www.omc.gov.ie/viewdoc.asp?fn=/documents/Publications/Implementation_Plan_from_Ryan_Commission_Report.pdf, retrieved on 15 January 2010.

The Ryan report implementation plan also contains a commitment to an out of hours social work service, although it is a matter of concern that there is no target date for the provision of this.[73]

(m) Initiatives of the HSE since the commencement of this investigation

The HSE has also undertaken a number of important initiatives which should be briefly mentioned.

The first was the completion of a *National Social Work and Family Support Survey* in April 2009. It has been reviewed by this Office, but not published. The survey gathered an array of much needed baseline data on child protection and family support services in Ireland, and comes on top of earlier work to improve data collection.[74] One of the important purposes of this is to identify gaps and help match resources to need.

This is an important initiative, since at present resources do not always match need. Some of the most striking examples in 2008 were as follows:

- Galway had the highest number of reports to the social work department in the State. Dun Laoghaire had the 31st highest.[75] Both had the same number of social work posts.[76]
- Wexford had the 3rd highest number of reports in the State, but only the 20th highest number of social work posts;
- Cavan/Monaghan had the 4th highest level of reports in the State, but only the 23rd highest number of social work posts.[77]

It is recommended that resources be better matched to need around the State to ensure equitable service provision through evidence based resource allocation.

In February 2009, the HSE also established a Children and Family Services Task Force. Its work includes:

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[73] See Action 93 of the Ryan Report Implementation Plan, OMCYA, July 2009, available at http://www.omc.gov.ie/viewdoc.asp?fn=/documents/Publications/Implementation_Plan_from_Ryan_Commission_Report.pdf, retrieved on 15 January 2010.

[74] See the National Childcare Information Project, to develop an integrated information system for the collection and analysis of information on child care activities. See http://www.hse.ie/eng/services/Publications/services/Children/nciss.html, accessed on 14 February 2010. The Department of Health and Children also ensured that an interim dataset was gathered pending the completion of the NCCISP.

[75] Dun Laoghaire is now referred to as South Dublin.

[76] This disparity cannot be explained by differences in deprivation: Galway is 7th in the State for material deprivation. Dun Laoghaire is 20th. This ranking is based on the percentage of the population in the 10th decile according to the SAHRU index.

[77] See Health Service Executive, Review of Adequacy of Services 2008, available at http://www.hse.ie/eng/services/Publications/services/Children/review%2008.html, retrieved on 15 January 2010. Not all social workers in these statistics will be doing child protection social work.

- the development of formal child protection protocols to ensure standardised and consistent practice within the HSE which is fully consistent with *Children First;*

- the development of standardised business processes for Family Support Services, Family Welfare Conferences and Children in Care;

- clarification of governance arrangements in child protection, including the roles and responsibilities of staff, including supervision; and

- development of a standardised approach to statutory care planning.

The HSE also appointed a full time Assistant National Director for Children and Families Services in November 2009.

The work of the Taskforce has positive potential – although it remains to be seen whether and to what extent it will be implemented. But it cannot make up for the lack of *cross-departmental/interagency* working identified above. And while it may improve matters moving forward, this Office must ultimately base its judgment on actions to date, rather than on work to change matters for the future, however positive it may be.

It must be hoped that this work will remedy some of the clear deficits in implementation, which the reviews above have disclosed and which are underlined by the analysis of implementation conducted by this Office, the results of which are outlined in Chapter IV below.

(n) Reviews of Adequacy

A final point should be noted about the HSE's performance of its duties regarding child protection. Section 8(1) of the Child Care Act 1991, as amended, states:

> "(1) The Health Service Executive shall—
>
> ...
>
> (*b*) annually ... prepare a report on the adequacy of the child care and family support services available in each functional area of the Executive."[78]

Therefore the HSE is under a duty to prepare a report on the adequacy of the child care and family support services available in each functional area.[79]

Each year the HSE does this through its Review of Adequacy of Services. In 2006 and 2007 the Review of Adequacy of Services consisted of a single document, which was published, along with detailed reports from Local Health Offices in which they assessed the adequacy of their services, which were not published. The unpublished documents for 2006 were,

[78] As inserted by Part 6 of Schedule 7 to the Health Act 2004.
[79] As to which, see s.67 of the Health Act 2004.

however, the subject of freedom of information requests by journalists. This led to considerable media coverage in February 2009, which highlighted inadequacies reported by Local Health Offices with service provision.[80]

The format of the Review of Adequacy for 2008, which was published in November 2009, changed radically. A summary document was still produced which was reasonably similar to the public documents produced in 2007 and 2006. Detailed statistics were also provided for each Local Health Office. But Local Health Offices were not asked to determine the adequacy of services in their areas – and did not do so.

What is of concern to this Office is that there was no real determination of the adequacy of the services provided by *each* functional area of the HSE. Instead, there was only some statistical information on services in each Local Health Office along with a general determination of adequacy throughout the State.

Of course, there is no requirement that adequacy be determined by the functional areas themselves. But adequacy does have to be determined in each functional area by somebody, whether an outside consultant, staff in each area, or a member of the HSE at national level. The failure by the HSE to ensure determination of adequacy in any meaningful way in 2008 does not give proper effect to the intent of s.8 of the Child Care Act 1991.

For this reason, the Review of Adequacy 2008 conducted by the HSE is contrary to sound administration within the meaning of s.8 of the Ombudsman for Children Act 2002.

The obligation to report on the adequacy of child care and family support services in each functional area is an important mechanism by which the HSE can gauge the implementation of aspects of Children First locally. The failure to give proper effect to s.8 is therefore also relevant when drawing overall conclusions regarding the implementation process. This is considered further below.

(o) Revised Children First Guidelines

First, however, it is worth noting that in December 2009 OMCYA completed its revised Children First Guidelines. They have not yet been formally launched, however, and at the time of writing had not entered into force. Henceforth, these Guidelines are referred to as the "revised Guidelines", while the original Guidelines are referred to simply as "Children First."

[80] See, e.g., "Children at risk as poor resources hamper services" and "Childcare reports: around the country", Carl O'Brien, Irish Times, 2 February 2009; Family drug and alcohol abuse key concern for child services, Jennifer Hough, The Examiner, February 03, 2009, available at http://www.irishexaminer.com/ireland/idmheysnql/#ixzz0dGLN4Vt4, retrieved on 21 January 2010.

Of course, it is compliance with the original Guidelines that this investigation is concerned with. It is nonetheless worth noting the revised Guidelines. By and large, these are very similar to the current Children First Guidelines. The main differences are set out at **Annex D**.

While the revised Guidelines provide welcome clarification in a number of areas, there is one significant area where existing procedures are substantially weakened. As mentioned above "Case Management Reviews" are reviews that must take place following serious incidents. The revised Guidelines call them "Serious Incident Reviews." Under paragraph 5.21.3 of the revised Guidelines a serious incident review must happen in the following circumstances:

- when the case of suspected or confirmed abuse involves the death of a child *in care or a child known to the child protection services*;
- when the case of suspected or confirmed abuse involves the serious injury of a child *in care or a child known to the child protection services*;
- when a child protection issue arises which is likely to be of significant public concern.

Paragraph 8.25.2 of the Children First guidelines did not contain the italicised text. This change was significant. It meant that serious incident reports would no longer be needed into the death or serious injury of a child if the child was not known to the child protection services. This was so even if other parts of the HSE were aware that the child was abused or the child's school or GP were aware. While, of course, it could be argued that the whole of the HSE should concern itself with child protection – it cannot be argued that the whole of the HSE is a child protection *service*. That is why it appeared that a serious incident review would not be required if, for example, a child was not known to a social work department but was known to the Child and Adolescent Mental Health Service.

At a time when Ireland should be improving its procedures for reviewing child deaths, it was a matter of serious concern to this Office that existing mechanisms for reviewing child deaths were being weakened in this way.[81]

This Office therefore raised this matter with the OMCYA in February 2010. It responded that it would amend the revised Guidelines to take account of this concern. The Ombudsman for Children welcomes this commitment.

This Office's analysis of the revised Guidelines, which was forwarded to the OMCYA, also pointed out that the revised Guidelines, like Children First, did not apply explicitly to churches and that, although the wording could more easily be interpreted as applying to churches, the matter remained unclear. The revised Guidelines apply to those providing services to children, including voluntary and community groups. But, for example, religious instruction is not commonly viewed as a service, nor yet are churches commonly viewed as voluntary or community groups. The OMCYA responded stating its view that the revised Guidelines did apply to churches and that implementation arrangements would reflect this position. *Given the well documented cases of clerical child sex abuse and the systemic*

[81] See in this regard the work of the Ombudsman for Children's Office on a child death review mechanism, as outlined in the Annual Report of the Ombudsman for Children, 2008, at page 44, available at http://www.oco.ie/whatsNew/annual_reports.aspx, retrieved on 14 February 2010.

failure to report such cases, it is recommended that the application of the revised Guidelines to churches be made explicit in the Guidelines themselves.

The revised Guidelines also do not contain a chapter on family support services. The OMCYA justified this on the basis that the purpose of Children First is to set out guidance regarding identification and reporting of child abuse. However, Children First, both in its original and revised formats, is entitled "National Guidelines for the Protection and *Welfare* of Children." In these circumstances, this Office believes that it is appropriate for it to have a chapter on family support services. However, what matters most is that *family support services, locally and nationally, are properly planned for with appropriate strategies in place and it is recommended that all necessary steps be taken to this end.*

This raises a more general point. As will be seen in Chapter IV, many parts of the State do not have local procedures - as required by the current Children First Guidelines, family support service plans – as required by the current Children First Guidelines and Regional Child Protection Committees and Local Child Protection Committees – as required by the current Children First Guidelines. None of these requirements feature in the revised Children First Guidelines. This Office trusts that these changes have been made with children's best interests in mind and that adequate alternatives nonetheless will be put in place, rather than simply because they were not being implemented in practice.

(p) Overall conclusions on the implementation process

Before assessing specific difficulties in implementation of Children First identified by this Office, it is worth drawing some conclusions about the overall implementation process.

First, it is clear that considerable efforts were made to implement Children First in the early years following its publication. In particular, the Health Boards Executive Resource Team did much work to overcome some important early difficulties with implementation, such as around the Child Protection Notification System.

Second, it is also clear that there have been a number of reviews of Children First. Each of these has highlighted problems with implementation in practice, including non-implementation of some aspects and variable implementation of others.

Where there has been greater weakness is in driving implementation forward in the period following the disbandment of the National Implementation Advisory Group and the Resource Team in late 2002. While it is certainly not suggested that interdepartmental groups needed to be standing arrangements, a coordinated approach of some kind was important to address outstanding state-wide problems – for example as regards attendance at Regional Child Protection Committees and Local Child Protection Committees as well as to ensure that Children First was fully embedded across government and that public bodies were

working together appropriately. Further, without such an approach, the six reviews of Children First served little purpose.[82]

One of those reviews, by the National Children's Advisory Council, had recommended maintaining and extending the remit of the National Implementation Advisory Group, rather than standing it down, and also recommended continued inspection and the drawing up of action plans to address shortcomings in implementation. It is a matter of regret that this approach was not followed.

However, this Office acknowledges the work of the HSE Taskforce since February 2009 and its positive potential and the work of the High Level Group, led by the OMCYA, in 2008.

But in the period from 2003 up to 2008 there appears to have been no body or group driving forward implementation effectively at OMCYA level and in the period up to February 2009 at HSE level. As a consultee to the OMCYA review observed:

> "Since the dissolution of [the National Implementation Advisory Group] there has been a lack of leadership at a national level. This in effect impacts on the standardisation of Children First nationally."

Of course, in the period from 2003 to 2004, the Interdepartmental group did meet. But this Office is not satisfied that implementation was driven forward by it. While departments at the group were asked to address problems that had been identified with the implementation of Children First, there is little evidence that this in fact happened and no evidence that there was follow up by the Interdepartmental group to help ensure that it happened.

Given the importance of Children First, and the consistent conclusion of Government commissioned reviews and surveys that there was variable implementation and, in some areas, non-implementation, *this Office concludes that the failure in the period from 2003 up to (but not including) 2008 to put in place appropriate mechanisms to drive forward interagency implementation of Children First involved unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002.* The OMCYA review stated:

> "The Department of Health and Children, through the OMCYA, has responsibility for overall strategic direction and policy in relation to child welfare and protection. This includes facilitating interagency cooperation and coordination around child protection and having a practical focus on identifying and solving problems between sectors."[83]

Accordingly, this Office concludes that ultimate responsibility for the unsound administration as regards interagency matters lay with the Department of Health and Children to the extent that it related to problems such as with Garda/HSE cooperation, variable implementation by

[82] Being the Health Boards Executive evaluation in 2002, the National Children's Advisory Council Review in 2002, the survey of the Interdepartmental group in 2003, the findings from the focus groups of the Conjoint Programme of Action in 2005, the HSE review in 2006 following the Ferns report and the OMCYA Review in 2008.

[83] See National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children, OMCYA, July 2008, at page 18.

health boards in the period prior to the creation of the HSE and the failure to ensure cooperation more generally – for example through Local Child Protection Committees and Regional Child Protection Committees. It is not suggested that the Department should resolve individual incidents. But it should work to resolve general problems of policy and help to ensure that adequate steps are taken to implement Children First on an interagency basis. Of course, this does not derogate from the individual responsibility of departments and public bodies to adopt proper child protection practices.

Separately, up until the Taskforce in February 2009, this Office concludes that insufficient efforts were made to drive forward implementation of Children First by the HSE internally, such as failure to ensure that Local Health Offices had local procedures, and that this involved unsound administration by the HSE in the period since its creation.

Equally, in the period from the disbandment of the Health Boards Executive Resource Team to the disbandment of the Health Boards themselves, this Office concludes that there was unsound administration by the Health Boards in failing to drive forward collectively problems that had arisen with Children First, including regarding its variable implementation.

In arriving at the above conclusions, this Office has taken into account the findings of Chapter IV of this report, detailed below. It has also taken account of the statutory roles of each of the above bodies.[84]

But this Office does not suggest that the Department of Health and Children/OMCYA has not made any efforts to implement Children First. In fact, real efforts were made to implement Children First, as detailed above. Further, the multitude of reviews shows the policy priority accorded by Government to Children First. The failure was not to make efforts to implement Children First, but to make *sufficient* efforts to drive its implementation forward at *particular times*, having regard to the importance of child protection and the importance that Government itself attached to Children First.

It is also not suggested that major new departures were required in the implementation of Children First while the OMCYA review process was underway from 2005 to 2008. But there were issues that certainly did need to be tackled, such as the establishment of Garda/HSE liaison teams where the Department's own 2003 survey revealed problems which, as Chapter IV demonstrates, endure to this day.

[84] While this Office accepts that variable implementation was in the first instance a matter for the health boards to resolve through the Health Boards Executive, under s.21(4) of the Health (Eastern Regional Health Authority) Act 1999, the Department was empowered to direct the Health Boards Executive to perform functions in the interests of efficiency and effectiveness. The Department therefore had the power to require the Health Boards Executive – and through it the Health Boards - to continue to work on the implementation of Children First. There is no evidence that it did so. The Department similarly has a power to direct the HSE under s.10 of the Health Act 2004. However, a finding is not made against the Department with regard to variable implementation by the HSE since it was easier for the HSE, as a single organisation, to address issues of variable implementation, than for the Health Boards Executive to do so, as the latter could only act with the consent of the health boards in the absence of a direction from the Minister.

In arriving at the above conclusions, this Office has taken into account comments made by the HSE and the OMCYA on a draft of this report in March 2010. In particular, this Office accepts that the period during which the finding of unsound administration has been made was also a period of substantial change within Irish health and social services, which saw the creation of the HSE and HIQA and a wider reform agenda. It is for this reason that this Office has refrained from finding unsound administration as a result of the *fact* of variable implementation. Rather, it was the failure to put in place effective *processes* to address variable implementation and other problems with Children First's implementation that led to the findings of unsound administration. Later in this report, specific findings of unsound administration are also made based on the fact of inadequate implementation, but only in sufficiently serious cases.

Also, just as this Office must take account of the wider reform agenda, it must also consider how child protection fared within that agenda. The fact remains in this regard that after 2003 it was only with the creation of the HSE taskforce in February 2009 that the HSE for its part put in place processes to address difficulties with implementation while OMCYA for its part only did so with the High Level group established in 2008 following the Dr A report.

This Office is aware that the HSE is undertaking a Strategic Review of the Delivery and Management of Child Protection Services. In the light of the foregoing, it is important that this review considers all options and asks new questions. *That should include whether child protection services are best delivered within the context of the HSE and, if concluded that they are, how to ensure that a focus on them is not lost amid wider concerns about health services.*

In comments received by this Office, the OMCYA also suggested that the OMCYA review was a "general, non-authoritative text" and that the above quoted passage regarding its function of facilitating interagency cooperation should not be read in isolation from the established functions of the OMCYA. For this – and other – reasons, it was urged that consequent finding of unsound administration against the Department of Health and Children should not have been made. This Office accepts that Children First itself does not state that the Department of Health and Children is to play this role in interagency cooperation. However, the Department nonetheless did so in 2000, again in 2003, and in 2008 through the High Level group established following the Dr A report. In such circumstances, if interagency cooperation on policy matters was to be a function of anybody but the OMCYA/Department, this ought to have been clearly stated. But it was not. It was stated to be the Department's function through the OMCYA in the OMCYA review.

This Office acknowledges the work done by the High Level group to improve interagency working and by the Taskforce within the HSE. However, it expresses real concern at the lack of evidence of any meetings of the High Level group in 2009, given the volume of outstanding work needed to be done on an interagency level and, moreover, the admitted failure to ensure mechanisms for interagency cooperation at local and regional level in many areas. However, the jurisdiction of the Ombudsman for Children to find an administrative practice to fall within s.8 of the Ombudsman for Children Act 2002 is not one that is exercised lightly. While a matter of real concern, this Office is not satisfied that the failure of the High Level group to meet during this period involves unsound administration within s.8.

It is nonetheless strongly recommended that the High Level group meet frequently to resolve all outstanding interagency policy issues regarding Children First identified in the context of the OMCYA review.

This Office has considered whether the failure to hold external inspection of child protection services involves unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002. As already stated, external inspection is a standard practice in England, Scotland, Wales and Northern Ireland. It also occurs or is scheduled to occur in Ireland with regard to children in residential care, in foster care and placed in the care of relatives.[85] This Office also believes that external inspection, particularly based on set standards, is consistent with good administration and international best practice and warmly welcomes the announcement that external inspection based on set standards will be re-introduced as of September 2011. This Office further believes that the decision to end external inspection of the implementation of Children First in 2003 was an entirely retrograde one.

However, having regard to the seriousness of a finding of unsound administration, this Office does not conclude that the failure to put in place *external* inspection falls within s.8 of the Ombudsman for Children Act 2002.

But this Office has noted with grave concern the findings of the Cork/Kerry audit summarised at (k) above. This was, as already stated, the only audit which involved an examination of case files. It found fundamental problems with the implementation of Children First – far more fundamental difficulties than any of the other reviews to date, which have tended to rely on surveys only. Without such auditing being conducted on a periodic basis there is the real danger of misdirection, with efforts being made to achieve advanced standards of implementation while basic issues are not addressed. That, in turn, could make the child protection system less – rather than more - effective.

While this Office would like to see casefiles also inspected externally, it is fundamentally important that they be audited internally. Equally, while it would be preferable to conduct inspections systematically throughout the State, what is critical is that audits of casefiles are conducted in some parts of the State from time to time at least so that there is a reasonable amount of objective data on implementation in practice. Simply conducting such an exercise in one part of the State (Cork/Kerry) once in a decade is not sufficient, especially when the results of that audit were so worrying.

It has been suggested to this Office that social work team leaders and Child Care Managers are alternative mechanisms for quality assurance. This Office accepts that both have important roles to play. But team leaders are normal line managers and while Child Care

[85] See respectively Article 31 of the Child Care (Placement of Children in Residential Care) Regulations 1995 (SI No 259 of 1995); Article 25 of the Child Care (Placement of Children in Foster Care) Regulations (SI No 260 of 1995); Article 25 of the Child Care (Placement of Children with Relatives) Regulations 1995 (SI 261 of 1995); and Article 18 of the Child Care (Standards in Children's Residential Centres) Regulations 1996 (SI No 397 of 1996). See also Action 39 of the Ryan Report Implementation Plan, OMCYA, July 2009, available at http://www.omc.gov.ie/viewdoc.asp?fn=/documents/Publications/Implementation_Plan_from_Ryan_Commission_Report.pdf, retrieved on 15 January 2010.

Managers do provide a quality assurance mechanism, for the reasons outlined in Chapter IV, their effectiveness has often been impaired. Neither, in any event, is an adequate substitute for internal audit.

This Office concludes that the failure by the HSE (and the Health Boards before 1 January 2005[86]) to put in place appropriate quality assurance through internal audit of casefiles more widely than in one part of the State (Cork/Kerry) and more frequently than once in a decade involves unsound administration and is therefore within s.8 of the Ombudsman for Children Act 2002, especially having regard to the worrying nature of the findings of the Cork/Kerry audit. This is particularly true in the absence of any systematic programme of external inspection. But even with external inspection, internal audit has an essential role to play.

It is also recommended that SSI, upon recommencing inspection of child protection work and consistent with its normal practice in other fields, examine case files to get a true picture of the state of implementation in practice.

There is a final general issue. It involves the handling of the industrial dispute in the Eastern Regional Health Authority region. This Office has not examined the rights and wrongs of the dispute. What concerns this Office is the lack of transparency regarding it – transparency being, of course, a general principle of sound administration. If the industrial relations dispute was submitted to be a barrier to implementation, then one would have expected the analysis of submissions to the OMCYA review to have said so. Equally, if the dispute was an actual barrier to implementation, then one would have expected the OMCYA review itself to have averted to this. But before making a finding on whether the lack of transparency was contrary to sound administration, this Office believes it appropriate to examine the impact of the dispute in practice, because if the dispute did not cause problems in practice, a lack of transparency would be less significant.

It is to this issue – and other issues considered when examining local procedures and in investigation meetings – that this report now turns.

[86] With the obvious exception of the Southern Health Board.

CHAPTER IV. ANALYSIS OF IMPLEMENTATION

(a) Methodology

As stated in Chapter I, this Office requested a copy of local procedures and any other documents demonstrating implementation of Children First from CCMs. All such documents were analysed. Through 9 investigation meetings with CCMs and correspondence with many others a fuller picture was gained of implementation on the ground. Investigation meetings were also held with the HSE nationally, IMPACT and the OMCYA and documentation was sought from each on different issues. An investigation meeting was also held with An Garda Siochána.

Relevant conclusions stated below were then put to the HSE nationally, Local Health Offices, IMPACT, An Garda Siochána and the OMCYA for comment. Comments were carefully considered. Most, however, did not take issue with the findings below. Of those that did, few submitted additional documentation challenging the conclusions drawn.

(b) The existence of local procedures

As already indicated, one of the requirements of Children First is that Health Boards draw up local procedures to implement Children First.

The local procedures must "adopt" chapters 3 and 4 of Children First on definitions and reporting of child abuse. The guidance on confidentiality in chapter 5 should also be adopted. It is also required that local procedures "reference" chapters 6 to 12 and chapter 14, supplemented by information on procedures locally. Local information would include details of training, the local approach to family support and clear descriptions of responsibility at local level of individuals and organisations.

This Office therefore requested and received, among other things, the local procedures applied by Local Health Offices. Responses were received from all Local Health Offices. Where there was a lack of clarity regarding any response received, this was followed up by this Office either in an investigation meeting or by way of correspondence.

North Lee, South Lee, Cork North, West Cork and **Kerry** responded together and supplied a single local procedure. This was an entirely acceptable response. Children First requires Health Boards to draw up local procedures, and the Local Health Offices in Cork and Kerry formerly constituted a single Health Board (the Southern Health Board). Similarly, **Clare, Limerick** and **North Tipperary** operated to the same local procedures, which date from October 2008. Similar, but more limited, local procedures were adopted by **Wexford, Waterford**, **Carlow/Kilkenny** and **South Tipperary**.

The Local Health Offices of **Galway**, **Mayo** and **Roscommon** were formerly part of the same Health Board. But their responses differed somewhat.

Roscommon supplied local procedures implementing the 1987/1995 Guidelines and local procedures implementing Children First. It was not indicated whether both or only one was in force. It was subsequently clarified in correspondence that the local procedures implementing Children First had replaced those implementing in the 1987/1995 Guidelines, which was reassuring given the differences between them.

The local procedures implementing Children First stated that they applied to Mayo, Roscommon and Galway. Mayo supplied these, which was entirely acceptable. However, **Galway** did not. In subsequent correspondence Galway stated that even though they may not have been initially supplied, they were being applied.

In the case of **Laois/Offaly** the local procedures supplied predated Children First and, in fact, implemented the 1987/1995 Guidelines. They were never revised to take account of Children First. It had been the view at the time that Children First was issued that the Guidelines were largely consistent with Children First. It is true that there are many similarities between Children First and the 1987/1995 Guidelines. But there are also important differences, as previously set out Chapter II and summarised in greater detail in **Annex A**. In short, the local procedures in Laois Offaly were not Children First compliant – even though the area had been innovative in many respects in delivering Children First on the ground. Laois Offaly has advised that it intends to adopt new local procedures.

Longford/Westmeath, like Laois/Offaly, belonged to the former Midland Health Board. Initially, it did not supply any local procedures, although a range of useful supporting documentation was provided. In subsequent correspondence, it was clarified that the same local procedures were being applied as in Laois/Offaly, that is to say procedures based on the 1987/1995 Guidelines.

Some areas supplied local procedures that were recently drafted. The procedures from **Dublin West** were short and dated December 2008. In correspondence and meetings it was made clear that these procedures were written in response to the request for local procedures by this Office. Prior to that there had been no local procedures, but the December 2008 procedures had described practice already largely underway.

In **North Dublin** the local procedures also dated from December 2008. The delay in producing procedures was ascribed to industrial relations issues and staff shortages. Prior to that the 1987/1995 Guidelines were operational, although aspects of Children First were also being increasingly applied over time. The procedures from **Dublin North West** also dated from December 2008. They had not been formally launched by November 2009 but it was asserted that they were nonetheless operational. **Meath**, for its part, provided local procedures from November 2008.

The local procedures from **Dublin South City** also dated from 2008 and only became operational in 2009. The procedures from **Dun Laoghaire** were also from 2008. It was later clarified that -

- they became fully operational only in March 2009 but work had commenced on them in 2007,

- a case conference protocol had also been put in place previously

- but that there had been no guidelines implementing Children First previously in place.

It was subsequently asserted that local procedures were in existence prior to this, but these were not submitted.

As of November 2009, the local procedures for **Donegal** were stated to be "not adopted as operational" although it was asserted that Children First was nonetheless being applied.

Wicklow provided brief local procedures, a Child Protection Conference protocol and guidance for the Child Protection Notification System. It also indicated that it applied the Health Boards Executive documents on initial assessment and on the Child Protection Notification System, discussed above. However, national documents are not local procedures and therefore this was not strictly Children First compliant.

The only local procedure supplied by **Dublin South East** was a Child Protection Conference protocol. Beyond that, it was simply stated that Dublin South East applied Children First. However, the failure to provide local procedures was not Children First compliant.

Dublin South West did not initially supply any local procedures, but rather only a very short document describing to this Office procedures being applied. Following further correspondence, operational guidance for the management of the Child Protection Notification System was provided and on child protection case conferences. Beyond this, no local procedures for the implementation of Children First were supplied.

Similarly, **Kildare/West Wicklow** did not supply any local procedures. Instead, a very short memorandum to this office outlined the procedures being applied. It was indicated that the development of local procedures was a priority for the coming year for that Local Health Office.

Dublin North Central, by contrast, provided detailed local procedures from 2005 which were among the best produced by any Local Health Office. They were filled with detailed local information on contacts and services, while also largely complying with Children First.

As well as a cover memorandum to this Office, **Louth** provided a Child Protection Policy Protocol. Beyond this, no local procedures were supplied. As with many other Local Health Offices that did not have proper local procedures, it was stressed that the area nonetheless worked to Children First.

Sligo/Leitrim supplied a number of documents. One of these, for example, set out local procedures for assessment. But there was no complete local procedure of the kind envisaged by Children First.

Cavan/Monaghan provided a Child Protection Protocol and the Health Boards Executive Explanatory Guide to the Child Protection Notification System, but no proper local procedures beyond that.

(c) Does it matter if local procedures are not developed?

It is a requirement of Children First that Health Boards have local procedures. But it is clear that, in reality, many Local Health Offices do not have such procedures. How much does this matter?

First of all, it is important to emphasise that *the failure to devise local procedures does not mean that an area is not implementing Children First at all*. It merely indicates that an aspect of it – the requirement for local procedures – is not implemented. Thus, for example, in **Longford/Westmeath**, while Children First compliant local procedures were not drawn up, training took place, Children First forms were introduced, a child protection conference protocol was developed, and a survey to assess implementation was carried out - among many other things.

There is therefore an argument that it does not matter that local procedures have not been implemented so long as practice on the ground is good. However, this Office is not convinced by this: in order to ensure consistency there should be some guidance for staff.

A better point - put by some CCMs - is that Children First already provides exhaustive guidance. While it is true that Children First did provide very detailed guidance, the value of local procedures is in the provision of *local* information to guide the implementation of national guidelines. The point is well illustrated by the very good procedures supplied by **Dublin North Central**. These provide detailed information on services available locally, as well as complying with Children First. The result is guidance that is accessible, useful and largely Children First compliant.

Another argument that could be put is that local procedures only encourage inconsistent implementation – and that a number of reviews (including this investigation below) have revealed inconsistent implementation to be a major problem. While there is some force in this argument, this Office is not, on balance, persuaded by it. Variable implementation could doubtless occur if local procedures are incomplete or inconsistent with Children First. But good local procedures should not be incomplete or inconsistent with Children First.

It could be argued that drawing up local procedures takes time and effort. However, again, this Office is not persuaded by this argument. Children First only requires that certain aspects of the text be adopted, other parts need only be referenced. The result is that local procedures do not need to be as long as Children First itself.

There are also two additional reasons why the failure to adopt local procedures mattered.

First, and most importantly, the requirement for local procedures was central to the Children First – and chapter 15 of the Guidelines was devoted entirely to the subject. It was therefore not sound administration for so fundamental a requirement to be avoided.

Second, Children First requires not merely Health Boards to draw up local procedures, but also – for example - hospitals, mental health services, education services and voluntary and community organisations.[87] Because the requirement for local procedures by the Health Boards was part of a wider policy of requiring local procedures, it follows that the requirement for local procedures did not disappear when the HSE was created. Moreover, the failure to ensure local procedures within the HSE compromised the leadership role of the HSE in encouraging voluntary and community organisations to have local procedures. After all, if local procedures were required of all, but HSE areas do not have them, voluntary and community groups may be uncertain as to the need for them too. Indeed, a manager in an area that had not consistently had local procedures pointed out that "for a long time voluntary agencies were never sure what the HSE was doing but were aware that Children First was not implemented."

It is notable that the revised Children First Guidelines issued in December 2009, but not yet in force, do not require the HSE to have local procedures - and in March 2010 information supplied to this Office by the HSE indicated that local procedures would not be used by the HSE in future.[88] But for so long as local procedures were required, they should have been put in place.

This Office therefore concludes that the HSE in failing to ensure that Local Health Offices all have local procedures acted contrary to sound administration within the meaning of s.8 of the Ombudsman for Children Act 2002.

(d) The Industrial relations dispute and local implementation

It was noted above that the prioritisation agreement did not mention Children First. IMPACT took from the agreement that administrative aspects of Children First did not have to be performed and the overall status of Children First became uncertain.

It was also noted that, despite submissions to the OMCYA review regarding the effect of the industrial relations dispute, nowhere in the analysis of submissions done in that review or in the conclusions of that review was the industrial dispute mentioned. This was despite the fact that the Department was aware from its own survey conducted in 2003 that industrial relations issues were impeding implementation.

It was also pointed out that this breached the principle of transparency. But before concluding on whether this was unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002, it is appropriate to assess what the effect of the industrial relations dispute has been. This is because if it was insignificant, it might be considered not worth mentioning in the OMCYA review or in the analysis of submissions.

[87] See page 121 of Children First at para. 15.2.1.
[88] See para 4.3 of the revised Children First Guidelines.

First, it is clear to this Office from its correspondence and/or investigation meetings that a number of managers had difficulties with developing local procedures. One stated that it had been difficult to have local guidance discussed because of the industrial relations issue and that some staff did not turn up at meetings where it was being developed and did not comment on drafts.

It was also notable that some local procedures developed in the Eastern Regional Health Authority region did not specifically state that they were implementing Children First. And some were instead described to this Office as being "in the context of" Children First or not implementing but reflecting "the essence of" Children First.

The current status of Children First also remains unclear. One HSE manager stated that social workers would not say that they were working to Children First and commented that, as a result, voluntary groups were for a long time uncertain what the HSE was doing. Another believed that if it was stated that Children First was being implemented, there could be a reaction from social work staff.

The prioritisation agreement also meant that full implementation of Children First was not, in reality, a priority. Despite this, it is clear that Children First briefings and training did go ahead in the former Eastern Regional Health Authority region. But important paperwork associated with Children First was not done in parts of the region. One manager described the situation as follows in a former Eastern Regional Health Authority community care area:

> "The paperwork is not being completed but they are doing everything else in the spirit of Children First. The practice is the same. The paperwork involves – reports, assessment reports, notifications ... and ... Garda notifications. Notifications are on the Social Work Information System so [they are] not using Child Protection Notification System notifications. Social Work Information System reports go to the CCM who notifies Gardaí. The joint action sheets are not being completed.
>
> "*The fact that these are not being implemented means that the CCM does not get written reports, so there is no evidence of what is being done and it is difficult to know what is being done. The CCM gets verbal reports ... [but] this can result in the CCM not being given full information."*

(The Social Work Information System is a database used by social workers in most of the State.)

IMPACT, for its part, stated that while Child Protection Notification System notification forms were being completed, Garda forms and initial assessment forms were not being completed.

In another area, a pilot for implementation of Children First was unable to go ahead in 2004 – and the situation was reported as part of the Performance Verification process for Sustaining Progress (Social Partnership Agreement) in 2005 and again in March 2006. But since then, staff had shown a greater willingness to work in line with Children First and were well disposed to it. The problem was that they would not say that this was what they were doing.

Another manager commented that while in their area Children First was applied, it was hard to have a discussion about Children First with other managers because some took the view that they were unable to have a discussion regarding it due to the industrial relations issue.

This Office concludes that that the industrial relations issue had real implications for Children First's implementation in the former Eastern Regional Health Authority region – and in many areas this held up Children First's implementation.

In some Eastern Regional Health Authority areas, local procedures have now been adopted that are consistent with Children First. But they do not explicitly claim to implement Children First. Even that negatively impacts on the HSE's leadership role in promoting Children First in the voluntary and community sector. In other areas, more significant difficulties remain with paperwork that ensures accountability and/or records the grounds for decision making, such as with Garda notifications.

The dispute was therefore a matter of legitimate public interest and concern – and OMCYA must have known this. It is not suggested that public bodies are under a duty to regularly inform the public of any industrial relations issues that arise. But Children First was specifically reviewed by the OMCYA from 2005 to 2008. This had the appearance of a transparent exercise – with an analysis of submissions and a report published – but was not in reality a fully transparent exercise. Accurate and repeated concerns were raised by informed professional consultees in this context about the industrial relations dispute – but not reflected in the published documents, or otherwise externally communicated.

This Office believes that in its analysis of submissions to the OMCYA review and in the OMCYA review document itself proper mention should have been made of the real industrial relations issues that had arisen, given their effects on the ground. This Office concludes that the failure to be transparent about the industrial relations dispute in the OMCYA review and analysis of submissions involved unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002 on the part of the Department of Health and Children through the OMCYA.

This Office further recommends that efforts be made on all sides to resolve all outstanding industrial relations issues affecting the implementation of Children First. This difficulty must be overcome.

(e) Specific aspects of local procedures

As well as assessing whether Local Health Offices had local procedures, this Office assessed in detail the compliance of those local procedures with Children First.

In this section, we set out some of the more important conclusions of this exercise. This includes assessment of the local procedures of **Donegal** and **Dublin North West**. However, it should be borne in mind that, as of November 2009, these had not been formally operationalised.

i. Definitions

Children First requires that the definitions of child abuse in Chapter 3 of the Guidelines should be "*adopted*" in local procedures.[89]

Yet no definitions were adopted in the local procedures provided (if any) by **Wexford**, **South Tipperary**, **Waterford**, **Carlow/Kilkenny**, **Sligo/Leitrim**, **Dublin South West**, **Kildare/West Wicklow**, **Cavan/Monaghan**, **Louth** and **Dublin South East**.

Definitions were provided in the Child Protection Conference protocol in **Longford/Westmeath**. But Longford/Westmeath, like **Laois/Offaly**, also operated local procedures that implemented the 1987 Guidelines which had definitions that were in some significant respects different.

Definitions were referred to, but not adopted, in **Wicklow, Cork West, Cork North, North Lee, South Lee** and **Kerry**. Strictly speaking this is not Children First compliant. Separately, **Roscommon, Galway** and **Mayo** adopted the basics of the definitions, but none of the important elaboration on them contained in Children First. This is unfortunate as it could lead to confusion in practice.

Definitions were adopted by **North Tipperary, Clare, Limerick, Dun Laoghaire, Dublin North Central, Meath** and **Dublin West** (though in a shorter format)**.**

Definitions were provided but were in some respects inconsistent with Children First in **Donegal** and **Dublin South City, Dublin North West** and **North Dublin.**[90]

Some areas – like **Wexford** and **Galway** - which did not set out definitions either completely or at all in local procedures nonetheless stated that they applied Children First definitions. However, Children First requires that definitions be adopted *as per* Chapter Three. The revised Children First Guidelines retain this requirement (although, of course, they do not require Local Health Offices to have local procedures).[91] This Office concludes that clarity around definitions is a key requirement of Children First and that the failure to ensure this risks the problem of variable implementation and may undermine the role of the HSE in promoting the adoption of local procedures by voluntary and community groups.

In view of the foregoing and the fact that the adoption of definitions is a key present requirement of Children First, the failure to ensure consistent definitions across the HSE involves unsound administration by that public body within the meaning of s.8 of the Ombudsman for Children Act, 2002.

[89] At p.121.
[90] Definition of physical abuse not properly implemented.
[91] See Appendix 9 of the revised Children First Guidelines.

ii. Basis for reporting

Along with providing definitions, Children First sets out the basis for reporting concerns.[92]

However, this was not sufficiently or at all provided for by **Wexford**, **South Tipperary**, **Waterford**, **Carlow/Kilkenny**, **Sligo/Leitrim**, **Donegal**, **Dublin South West**, **Laois/Offaly**, **Longford/Westmeath, Kildare/West Wicklow**, **Dublin North West**, **Dublin North Central**, **Cavan/Monaghan**, **Meath**, **Louth**, **Dublin West, Longford/Westmeath** and **Dublin South East.**

By contrast, this was provided for in the **Cork West, Cork North, North Lee, South Lee, Kerry, North Tipperary**, **Clare**, **Limerick**, **Roscommon**, **Mayo**, **Galway**, **Dun Laoghaire**, **Wicklow**, **North Dublin** and **Dublin South City**.

In some cases, for example **Laois/Offaly**, this had been addressed through training. However, the recent Murphy report highlighted the importance of precise adoption of the basis for reporting in Children First.[93] Further, this is an area where the existing Children First requires local procedures to "adopt" the basis for reporting.[94] And, given that under present Guidelines this is required of Local Health Offices, it appears damaging to the role of the HSE in promoting local procedures by the voluntary and community sector that this was not uniformly done. *In view of the foregoing, the failure to ensure clarity and consistency regarding the basis for reporting child abuse concerns across the HSE in local procedures involves unsound administration within the meaning of s.8 of the Ombudsman for Children Act, 2002.*

iii. Committee structures

- Regional Committees

Children First requires Regional Child Protection Committees with certain functions, particularly as regards interdisciplinary working.[95]

Mention of a Regional Committee was made in the local procedures of **Dublin North Central**, but it was not clear that it was meeting. Mention was also briefly made of a Regional Committee in **Dublin West**, but no detail was provided there or elsewhere of its work or whether it was meeting.

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[92] At pp.37-38.
[93] See Commission of Investigation, Report into the Catholic Archdiocese of Dublin ("The Murphy report"), Part 1 at pages 84 to 86.
[94] The revised Children First Guidelines also require exact adoption of thresholds, though local procedures are not clearly required of Local Health Offices. See Appendix 9 of the revised Children First Guidelines.
[95] At Appendix 5 and page 48.

There was a Regional Committee in **Longford/Westmeath**, but it is not meeting any more (and may not in fact have performed the functions of the Regional Committee envisaged by Children First). It also covered other areas within the former Midland Health Board (e.g. **Laois/Offaly)**.

However, no mention of Regional Committees was made in the documents received from **Waterford**, **Wexford**, **South Tipperary**, **Carlow/Kilkenny**, **Cork West, Cork North, North Lee, South Lee, Kerry**, **North Tipperary**, **Clare, Limerick, Sligo/Leitrim, Dublin North West, Cavan/Monaghan, Louth** and **Dublin South East.**

It appears from information provided in local procedures and other documentation that Regional Committees are not meeting regularly or at all in **Roscommon, Mayo, Galway, Dublin South West, Dun Laoghaire, Kildare/West Wicklow, Wicklow, North Dublin** and **Meath.**[96]

The relationship between the Regional and Local Committees in **Donegal** was unclear from documentation. In **Dublin South City** mention is made of a Regional Committee but its role appeared confused with that of the Local Committee. Also, it no longer meets and – as set out below – it was viewed as ineffective.

The foregoing involved only an examination of local procedures and other documentation provided and does not definitively establish whether Regional Committees were or were not meeting.

However, correspondence and investigation meetings confirmed that regional committees were generally not functioning and in many cases had never functioned. For example:

- **Dublin North Central** confirmed that no Regional Committee was meeting in its area;
- In **Dublin South City** the Local Area Protection Committee reported to a Regional Committee, but neither was perceived to be successful due to a lack of power.
- In **Dun Laoghaire**, the establishment of the Regional Committee was delayed, which meant that local committees "did their own thing" within the framework of the Children First guidelines. Ultimately, the Regional Committee never met in the former **East Coast Area Health Board**.
- In the former **Midland Health Board** the Regional Committee met but it was felt that it lacked power to affect what was happening on the ground. It no longer meets.
- No Regional Committee was established in the former **Southern Health Board**.

[96] In **Galway** the local CCM had written to HSE management in September 2008 to seek clarification if new committee structures would be established to reflect the new HSE regional structures.

- **Wexford** stated that instead of a Regional Child Protection Committee, there was a Regional Advisory Committee. However, it was disbanded upon the creation of the HSE.

Many of those who spoke or corresponded with this Office also had found it a challenge to ensure attendance at Regional Committees. This was not surprising. Other services - such as education, an Garda Síochána and social welfare - did not follow the Health Board structure. So attendance – particularly by those with authority for the area – was problematic.

- Local Committees

Children First currently requires Local Child Protection Committees with certain functions.[97]

However, no mention of Local Committees was made in the documents received from **Waterford**, **Wexford**, **South Tipperary**, **Carlow/Kilkenny**, **Cork West, Cork North, North Lee, South Lee, Kerry**, **North Tipperary**, **Clare**, **Limerick**, **Sligo/Leitrim**, **Galway**, **Laois/Offaly**, **Cavan/Monaghan**, **Louth** and **Dublin South East**.

It appeared from documents supplied that the Local Committee was not meeting regularly in **Roscommon**, although the documents supplied were contradictory on this point. It also appeared from documents supplied no longer to be meeting in **Dublin South West, Dun Laoghaire** and **Wicklow**.

In **Dublin North West** the Committee had yet to be established and was not meeting in **North Dublin** and **Meath**.

There was evidence of Local Committee activity in **Mayo, Kildare/West Wicklow**, **Dublin North Central** and **Dublin West**. In **Longford/Westmeath** it was stated that an interprofessional committee met "as required."

The relationship between the Regional and Local Committees was unclear in **Donegal** and in **Dublin South City**.

Again, this review of local procedures and related documentation supplied was not conclusive on whether local committees were meeting. But the overall impression of many local committees not meeting was borne out by subsequent correspondence and investigation meetings. For example:

- in **Dublin North Central** it was confirmed that the local committee no longer met – although a committee for a specific area within Dublin North Central had been established;

[97] At Appendix 5 and page 48.

- in **Dublin South City** the local committee ceased to meet shortly following the creation of the HSE;

- in **Laois/Offaly** there was difficulty getting buy in to a local committee and it was felt that it was sufficient to have a regional committee;

- by contrast, in **North Dublin** the local committee was not meeting. The reason given to this Office was that there was no regional committee or strong national structure for it to feed into. The same difficulty was raised by **Wicklow** and **Wexford** while **North Lee** also raised a perceived lack of authority and meaningful role in relation to practice. The fact that some professionals were unable to represent their profession was also cited as a difficulty by **Wexford**.

But in other areas – like **Dublin West** – regular meetings did occur bringing together all stakeholders.

Again, a key problem raised by many of those contacted by this Office was attendance, and the fact that – for example – schools and general practitioners could not represent each other when attending. This was, of course, because administrative structures for other Irish public - and indeed private - services did not follow the Local Health Office structure of the HSE.

- ***Conclusions***

The above findings confirm that the regional and local committees are not working effectively. It is notable in this regard that the revised Children First Guidelines do not require Local Child Protection Committees and Regional Child Protection Committees.

Undoubtedly, a key problem was that other service providers were not organised according to Local Health Office or Health Board boundaries. But clearly it is vital that there be *some* effective coordination, be it at local, regional or state level to address interagency and multidisciplinary issues, such as problems with exchange of information, confidentiality and data protection concerns, all of which were clearly identified as issues either by the OMCYA review or submissions made to that Review. Yet in the period up to 2008, for most of the HSE/Health Boards such structures either did not exist or work effectively.

As already stated*, this Office concludes that the failure to ensure effective structures for addressing interagency issues, be it at local, regional or national level up to (but not including) 2008 involves unsound administration within the meaning of s.8 of the Ombudsman for Children Act, 2002. Since the resolution of interagency policy issues is a stated function of the Department of Health and Children, this finding is made against that Department.*

This Office notes that the OMCYA review proposed that many of these issues be dealt with at national level by the High Level Group established following the Dr A report. Evidence was provided that the High Level Group met in 2008, but not at all in 2009 as it was decided to await the publication of the revised Children First Guidelines.

In view of this, the finding above is limited to the period up to (but not including) 2008. This Office does not accept that it was acceptable for the Group not to meet during 2009 pending the publication of the revised Children First Guidelines. As already stated, there was much important work that could have been done during that time. However, and with some hesitation, no finding of unsound administration is made given the seriousness of such a finding. *But, as already stated, it is strongly recommended that the High Level Group meet to resolve outstanding cross-sectoral concerns regarding Children First, as identified by the OMCYA review and the submissions to same.*

iv. Assessment procedures

Chapter 8 is possibly the most important chapter of Children First. It sets out how allegations raising child protection issues should be investigated.

A review of the documentation supplied suggests that the following have substantially set out in their local procedures the requirements of Chapter 8: **Wexford**, **Waterford, South Tipperary**, **Carlow/Kilkenny**, **Cork West, Cork North, North Lee, South Lee, Kerry, North Tipperary, Clare, Limerick, Dublin North Central, Meath, Dublin South City** and **Dublin West.**

There were some differences between Children First and the procedures in **Donegal**. **Sligo/Leitrim**, **Laois Offaly** and **Longford/Westmeath** failed to supply local procedures adequately implementing chapter 8.[98] Only very bare details were provided by **Dublin South West** and **Dublin North West**. Some detail was supplied by **Dun Laoghaire**, **North Dublin**, **Cavan/Monaghan** and **Louth**.

Roscommon, Galway and **Mayo** supplied procedures, but they did not appear to be Children First compliant as they did not appear to envisage conducting a full assessment. However, in subsequent correspondence **Galway** stated that full assessments were completed – but were called initial assessments, while **Mayo** confirmed that full assessments were conducted using various different models.

No clear written procedures were supplied by **Kildare/West Wicklow, Dublin South East** and **Wicklow.** To be fair, Wicklow did supply national documents that it confirmed were in operation, but – strictly - this is not sufficient to comply with the requirement for local procedures.

[98] There are indications in some slides provided by Longford/Westmeath that procedures comply with chapter 8. However, slides are a training material rather than a proper local procedure. Meanwhile the local procedures reflected the 1987 Guidelines.

The foregoing was only an assessment of the local procedures supplied. This Office therefore decided to explore this matter further in investigation meetings, correspondence and through an examination of the Reviews of Adequacy conducted by the HSE in 2007 and 2008.

The following were the key findings:

- ***Initial assessment***

There is a huge variation with regard to practice on initial assessments. For example:

- In **North Dublin**, in 2008 of 759 social work reports, all 759 received initial assessment. Similarly, in the previous year every case got an initial assessment. In **Dun Laoghaire**, of 185 social work reports, all 185 received initial assessment.
- By contrast, in **North Lee**, of 912 reports, 133 received initial assessment. The figures for 2007 are even more stark. Of 1,000 reports only 11 received initial assessment.[99]

The HSE has explained these differences as being caused by local differences in definitions and procedures. It has stated:

> "There are ... some significant variations in numbers of reports to social work departments and numbers of reports which had an initial assessment. These variations are accounted for by local differences in definitional frameworks, organisation structures, work practices and business procedures...."
>
> "These factors influence how cases are defined at point of entry into the service in terms of child abuse or child welfare, and influence how cases are processed through the system." [100]

In particular, it is clear to this Office that this variation was caused by some areas treating preliminary enquiries, or screening, as equivalent to initial assessment. As discussed in Chapter II above, this difficulty was caused by Children First itself being unclear as to the difference between those two concepts. However, this matter was clarified by the Health Boards Executive's 2002 Explanatory Guide which clearly distinguished between screening and initial assessment.

[99] See the HSE Reviews of Adequacy of Services for Children and Families, 2007 and 2008, available at http://www.hse.ie/eng/services/news/2009_Archive/May_2009/ReviewofChildrenFamilies2007.html and http://www.hse.ie/eng/services/Publications/services/Children/review%2008.html respectively, both retrieved on 14 February 2010.

[100] Review of Adequacy of Services for Children and Families 2007, at page 12.

- ***Child Protection Notification System***

Just as the number of initial assessments conducted varies across the State, so too do the numbers accepted to the Child Protection Notification System. For example, **Dublin North Central** had 95 cases currently on the Child Protection Notification System at time of interview, **Laois/Offaly** had 52, **Dun Laoghaire** had 19 while **North Lee** had eight. Clearly, such a radical variation cannot be accounted for by variations in size of Local Health Offices or caseloads alone. It is clear that very different thresholds for the operation of the Child Protection Notification System are also a factor.

There was also a concern about the criteria for removal from the Child Protection Notification System. In interviews, one manager expressed a concern about what should be done when a child reached 18, believing the record of this should remain on the Child Protection Notification System, for example to identify risk to siblings – and also expressed the view that a case could be closed to the Child Protection Notification System even if there was ongoing risk. Another manager queried the utility of the Child Protection Notification System as a register for children at risk given that the thresholds in some areas were so high. Yet another spoke of cases coming off the Child Protection Notification System when a decision is reached. By contrast, the Health Boards Executive Explanatory Guide made clear that cases should not come off the Child Protection Notification System, but rather should only be closed to the Child Protection Notification System. Unfortunately, neither the original nor the revised Children First Guidelines made this clear.

Finally, the Child Protection Notification System is a record of all children about whom there is a child protection concern. It is not surprising therefore that filing in social work departments is by child. However, even though not specifically required by Children First, it is important that filing and IT systems also allow for searching by other criteria.

This is not the case at present and the problems that this can cause are well illustrated by the recent Murphy report into the Catholic Archdiocese of Dublin. It sought discovery of HSE documents related to allegations of abuse against all priests in the Dublin Archdiocese. The HSE responded that its files were by reference to the alleged victim only and were not cross referenced to the alleged abuser. It would therefore have to examine 180,000 files in order to ascertain all recorded allegations against priests in the Dublin Archdiocese, a process which the Murphy Commission calculated could have taken up to ten years.[101]

[101] See Commission of Investigation, Report into the Catholic Archdiocese of Dublin ("The Murphy report"), Part 1 at page 36.

- ***External and 24 hour access***

Children First requires that external agencies have 24 hour access to the Child Protection Notification System.[102] An even more fundamental challenge to the utility of the Child Protection Notification System as a warning system is that in very few cases did the investigation find evidence that there was any external 24 hour access to the Child Protection Notification System.

Indeed, it was clear that there was no such access in **Laois/Offaly, Dublin West, Dun Laoghaire, North Dublin, Dublin North Central** and **Dublin South City**.

It was only in the former Southern Health Board area (**Cork/Kerry)** that there was evidence of external 24 hour access to the Child Protection Notification System. Some hospitals in that area had access and negotiations were underway in the case of another. However, getting access for hospitals had been a protracted process, with some hospital staff expressing concern at becoming involved in child protection work.

Further, there appeared to be no area of the State where an Garda Síochána had 24 hour access to the Child Protection Notification System. An Garda Síochána did state, however, that it had compiled a record regarding children with whom the service had come into contact out of hours. For that reason, it was also asserted that access to the Child Protection Notification System was not needed.

A further problem was that even in the few places where there was external access to the Child Protection Notification System, this still did not provide an indication of children at risk throughout the State, but only in that region.

- ***Role of Child Care Manager (CCM)***

A yet further problem was identified with the role of the CCM. Only in **Donegal, South Lee, North Lee, North Cork, West Cork, Kerry** and **Sligo/Leitrim** does the CCM hold line management responsibility for social work teams.[103]

With the exception of **Mayo**, it appears that elsewhere the CCM has no power of direction. That means that to be effective a CCM must have a good relationship with the Principal Social Worker – or else be able to secure a direction from the General Manager, who may not have a social work background. The designation "Child Care *Manager*" is therefore in most parts of the State essentially misleading.

[102] See page 157 of the Guidelines at paras 12 and 13. This requirement is retained in the revised Children First Guidelines.
[103] See Social Work and Family Support Survey 2008, HSE, April 2009, at p.180.

It is not suggested that the CCM necessarily should have line management responsibility, but the ability to direct to ensure proper service provision appears essential if this post is to continue.

Of even greater concern is the fact that in many parts of the State CCMs do not have guaranteed rights to information. Thus, for example, in **North Dublin** and **Dublin North Central** the CCM does not have access as of right to the Social Work Information System, the social work database. In **Dublin South City** the CCM had access only to management reports on the Social Work Information System and no access to case information. In **Dun Laoghaire**, the CCM did not see initial assessments before March 2009, although summary reports were written for Child Protection Notification Management Meetings.

A number of CCMs expressed the related concern that they were unable to verify whether there were cases which should have been notified to them, but were not. As one former CCM explained to the OMCYA review:

> "As a Child Care Manager ... I was tasked with receiving all notifications of suspected child abuse and ensuring appropriate action. However, the social work service had all the information pertaining to allegations on a database called the Social Work Information System. As Child care manager I was prevented from gaining access to that system. Therefore I had no access to check the effectiveness of practice."

Another CCM stated that while some social workers notified cases regularly to her, others did not. She had become aware of unnotified cases on some occasions when contacted by external agencies about such cases, or when subsequently asked by social workers for Child Protection Conferences on such cases. She also stated that the number of cases notified had varied from year to year as staff changed. For example, in one year they fell to a trough of only 12% of the figure for cases notified some years previously. Following staffing changes, the numbers notified not only recovered, but exceeded, their original level. The CCM believed that this was more satisfactory.

Some other CCMs, by contrast, indicated that they did not have difficulty accessing information.

One of the reasons given by a CCM for restrictions on the role of CCMs was the fact that they did not have to have a social work background – and some social work staff were opposed to management by non-social workers.

The overall effect of the above in many parts of the country was clear: the CCM had responsibility without authority.

- ***Conclusions***

The foregoing reveals a number of serious matters.

First, the variable understanding of what an initial assessment is or when a child should be notified to the Child Protection Notification System is a real concern. It means not only that there is a lack of consistency in implementation throughout the State, but also complicates even the compiling of statistics rendering the services offered by different parts of the State difficult to compare. An example of the effect of this can be seen in the HSE's own planning process.

A National Service Plan is completed every year by the HSE for the Minister's approval as part of the overall planning process. The National Service Plan 2009 has a section on Children and Families. It contains detailed targets and projected outturns. But under the heading Child Abuse no targets or projected outturns are provided. Instead, it is stated that progress will only be recorded for those areas that have rolled out standardised business practices as part of the National Child Care Information System.[104] In short, the ordinary process of setting targets and benchmarks is not, at present, possible on a state-wide basis, due the lack of standardised definitions and business practices.

This Office does not believe that differences in practice are always a bad thing. In some cases, they can encourage innovation and better targeting of local priorities. However, the failure to have common understandings of basic terms is a more serious matter, as it leaves the HSE unable to monitor effectively what is happening at local level or to set national targets or projected outturns.

This Office is aware, however, that the HSE has work underway to address this issue. Given that the HSE was founded in 2005, given the importance of standardised processes and that work to deliver standardisation is underway, along with work to improve the dataset, this Office does not propose to find that the HSE is responsible for unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002 solely because of the fact of variable implementation at this time. However, *it is strongly recommended that this work to standardise processes and improve datasets be continued as a priority. This should include clarity on screening and initial assessments, clarity on when to accept to the Child Protection Notification System and when to close a case to the Child Protection Notification System, as well as clarity on the non-removal of cases from the Child Protection Notification System.*

Also, in order to avoid the difficulties encountered by the Murphy Commission, *it is recommended that all necessary steps be taken to ensure that information be stored and searchable otherwise than solely on grounds of alleged victim, at least prospectively if it is not feasible to do so retrospectively.*

[104] See Report of the NCCIS Business Process Standardisation Project, HSE, October 2009, available at http://www.hse.ie/eng/services/Publications/services/Children/nciss.html, retrieved on 13 February 2010.

This Office is more concerned about the failure to provide for 24 hour external access. This is essential to ensure that external agencies – such as Accident and Emergency departments of hospitals – have proper information before them to assist them in deciding whether to report potential child protection concerns.

Further, while it is useful that an Garda Síochána are developing information regarding children who come to their attention afterhours, they also require information regarding children at risk identified by the HSE. Sharing information in this regard is a fundamental aspect of Children First. Similarly, this Office is concerned at reports that some professionals in some hospitals appear reluctant to accept the importance of the role that they need to play in child protection.

Given the importance of this issue, and the fact that this has been explicitly required by Children First*, this Office believes that the failure of the HSE to ensure 24 hour external access in most of the State involves unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002.*

A further matter of concern to this Office is that there is no access by external agencies to the Child Protection Notification System information from other areas. Without this, an abuser can better his or her chances of going undetected – for example - by bringing a child to hospital in another part of the State. *While this is not a requirement of Children First, given the reality that families and children can and do move between counties, it is recommended that consideration be given to the creation of a national Child Protection Notification System system, rather than only a local one.* This would require appropriate safeguards, of course.

Some steps have recently been taken, for example in the Dublin area, to provide an out of hours social work service for certain children[105] and the Ryan implementation plan contains a commitment to ensure an out of hours service throughout the State, but with no timeframe for achieving this.[106] *While not a requirement of Children First, this Office strongly recommends the rolling out of such a service throughout the State and that all necessary funding be given priority to this end.*

This Office has considered the current functions of CCMs and does not believe that responsibility without authority makes sense. Further, this Office is concerned at restrictions that exist in some Local Health Offices on access to information by CCMs. Such restrictions are untenable and can only hinder proper child protection practices. *It is noted that the current role of CCMs is under review and it is recommended that these issues be fully considered in that context.*

[105] See Review of Adequacy of Services for Children and Families 2008 at page 38.
[106] See Action 93 of the Ryan Report Implementation Plan, OMCYA, July 2009, available at http://www.omc.gov.ie/viewdoc.asp?fn=/documents/Publications/Implementation_Plan_from_Ryan_Commission_Report.pdf, retrieved on 15 January 2010.

v. Welfare issues

Children First requires consideration of family support services where notification is not required.[107] It also stresses the responsibility of Health Boards (and now the HSE) to provide such services, reflecting the statutory duty in s.3 of the Child Care Act 1991.[108]

Such support services can help to prevent the worsening of difficulties for families. They can also enable the HSE to track cases where risks exist but where the situation does not warrant a child protection notification.[109] Accordingly, local procedures were examined to check if they contained a commitment to deal with cases that raised welfare issues, as opposed merely to ones that met the threshold for abuse or neglect.

Areas that contained such a commitment were: **Dublin North West**, **Wexford**, **South Tipperary, Waterford, Carlow/Kilkenny, Cork West, Cork North, North Lee, South Lee, Kerry, North Tipperary, Clare, Limerick, Sligo/Leitrim, Roscommon, Mayo, Galway, Dun Laoghaire, North Dublin, Cavan/Monaghan, Wicklow, Meath,** and **Louth.**

Dublin South East and **Kildare/West Wicklow** did not have such a commitment.[110] Nor did **Longford/Westmeath** and **Laois/Offaly**, although the latter provided some evidence of acceptance of responsibility for welfare issues as envisaged by Children First while the former provided some documentation which mentioned welfare service activity. **Dublin South West** did not provide proper information on the commitment to welfare services, but it appears that the area participates in the National Assessment Framework pilot and the South Dublin Children's Services Committee, which may indicate a commitment to referral.

Similarly, while such a commitment is not recorded in the case of **Dublin South City,** it does refer to the need to have a family support service plan, although this was not provided. **Donegal** also refers to a project underway to try to link family support and child protection work better. In **Dublin North Central** it is not clear how welfare cases are handled and a family support local policy is only presently under consideration.

Due to pressure of urgent cases, **Dublin West** for its part makes clear that it does not itself handle welfare cases, but rather refers them on to the appropriate agency. This is not consistent with Children First which requires the drawing up of family support plans and agreements in appropriate cases. But it is not necessarily contrary to s.3 of the Child Care Act 1991 provided that it funds family support services.

Wicklow in correspondence also mentioned the difficulty that it had in handling welfare cases due to the pressure of child protection work.

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[107] At para 8.8.
[108] See generally Chapter 7.
[109] See para 7.2.1 of Children First.
[110] Kildare referred to family support plans and family welfare conferences in a letter to the Ombudsman for Children, but did not evidence an acceptance of responsibility for welfare cases clearly.

One of the specific requirements of Children First regarding welfare services is to require each community care area to have a strategy for the provision of such services. This should indicate how and which services would be funded or provided by the HSE and also should take account of the views of all relevant service providers and representatives of community organisations in the area.[111] As already stated, some areas referred to the desirability of developing such a strategy. But only two areas provided evidence that they had a completed family support service plan – these were **North Lee** and **Dublin South East**.

In investigation meetings it was specifically confirmed that many other areas did not have such plans, including **Dun Laoghaire, Dublin North Central, Dublin South City, Laois/Offaly,** and **North Dublin.**

However, the failure to have such a plan did not mean that efforts were not being made to match resources to need. Some CCMs provided evidence that this was nonetheless being done, albeit more informally. In other cases preparatory work had been undertaken. For example, in **Dun Laoghaire** the local children and families care group participated in extensive research into family support needs and an exercise mapping all the local family support services. It was intended to use this work to form a family support service plan.

While **Wicklow** did not provide a family support service plan, it did provide a submission to the 2005 review of adequacy conducted by the HSE under s.8 of the Child Care Act 1991 which contained considerable analysis and commentary on family support services in the area. Other areas are, of course, equally obliged to assess adequacy of their family support services in this context. However, as we have seen, the format and approach of the HSE to their reviews of adequacy changed in 2008, rendering this a less effective substitute for a family support service plan.

While this Office believes that family support service plans should certainly be drawn up, it is not believed that this omission of itself merits a finding of unsound administration contrary to section 8 of the Ombudsman for Children Act 2002. In arriving at this conclusion, this Office has had regard to the fact that the HSE has no promotional role in this area in the same way as it has as regards local procedures, nor is it a matter where staff providing such services clearly need guidance.

Nonetheless, it is a matter of regret that this work was not undertaken by far more Local Health Offices. *It is recommended that work be undertaken to ensure that family support services best match need on the ground, including through family support service plans.* Whether this is done at Local Health Office level or at some other level is less important – what counts is that it is done at some level.

[111] See para 7.2.3 of Children First.

vi. Joint Garda/HSE working

Chapter 9 of Children First sets out procedures for Joint Garda/HSE working. For example, it requires the use of joint action sheets, certain forms for notification and the identification of staff within each organisation for liaison purposes.[112]

Areas that complied with these requirements on paper were **Cork West, Cork North, North Lee, South Lee, Kerry, North Tipperary, Clare, Limerick, Galway, Mayo, Donegal, Dun Laoghaire** and **Dublin West**.

Areas that did not comply were

- **Wexford, Waterford** – which provided HSE/Garda protocols, although without local information. Joint action sheets were not in use.
- **South Tipperary, Carlow/Kilkenny** – which provided HSE/Garda protocols, although without local information. It was not confirmed that joint action sheets were in operation.
- **Sligo/Leitrim** which had references to notification of an Garda Síochána and strategy meetings, but did not provide notification forms, details regarding liaison structures or joint action sheets.
- **Roscommon** which indicated that it had good cooperation but this did not involve the formal liaison structures of Children First or joint action sheets.
- **Dublin South West,** which supplied very limited information, with no evidence of use of forms, joint action sheets or strategy meetings. It was indicated in a cover letter to this Office that there was a Garda/HSE Child Protection Notification Meeting Review Group.
- **Laois/Offaly,** where no information was supplied regarding joint action sheets but management meetings with the Garda Síochána were taking place.
- **Kildare/West Wicklow**, which did not have clear local procedures. The letter from this area claimed close Garda cooperation, but did not mention formal liaison structures or joint action sheets.
- **Wicklow** had formal liaison structures in place, but joint action sheets were not used.
- **Dublin North West**, which provided for liaison teams, but no information as to the use of forms or joint action sheets.
- **Dublin North Central** where joint action sheets were not in operation.
- **North Dublin** where joint action sheets were not in operation.

[112] See generally Chapter 9.

- **Cavan/Monaghan** where no information was provided regarding forms, including joint action sheets.

- **Meath** where there were no joint action sheets.

- **Louth** where, while it was stated that cooperation is good, there was no evidence of use of the forms and joint action sheets.

- **Dublin South City** where no forms, no joint action sheets and no structured liaison with Gardaí was evidenced.

- **Dublin South East** where there appeared to be liaison but no details regarding forms or joint action sheets.

- **Longford/Westmeath** where there appeared to be substantial cooperation but there was no mention of joint action sheets.

The foregoing may, in fact, overstate implementation. For example, in a follow up meeting it was stated that joint action sheets were not, in fact, in operation in **Dublin West**, contrary to what was stated in that area's local procedures which had been drawn up in December 2008. On the other hand, it was clear from meetings and correspondence that in **Donegal** joint action sheets were in use, but in **Dublin South City, Laois/Offaly** and **Dublin North Central** it was specifically confirmed that they were not in operation.

Further, in **Dublin North Central** it was confirmed that only informal arrangements for liaison were in place. In **Wexford** it was explained that joint action sheets were not in use because of a perceived lack of guidance on their use (for example on issues such as who should sign off on them).

Some other important points emerged from investigation meetings and correspondence.

First, both an Garda Síochána and the HSE had found joint training to be highly beneficial. However, on the HSE side there was concern that its benefits were quickly dissipated, with Gardaí frequently reassigned to other duties thereafter. *For this reason, this Office can see merit in the proposal for a dedicated child protection service within an Garda Síochána and recommends consideration of this proposal*. This could greatly facilitate the HSE in that it would reduce also the burden that liaison arrangements otherwise cause. For example, in **North Dublin**, a CCM stated that it was necessary for the HSE to liaise with "six to seven" different inspectors.

In a positive development, an Garda Síochána informed this Office in March 2010 that arrangements have been put in place with the HSE to design and deliver nationwide joint training on Children First. This is most welcome since training on joint interviewing can help to avoid the trauma and upset for a child that repeated interviewing by separate agencies can cause.

Ensuring joint working is not, however, merely a matter of joint training. It also requires the establishment of proper liaison structures so that joint working is not simply dependent on the vagaries of personal contacts and relationships. It is a matter of concern that those structures have not been formally established in significant parts of the State. *It is strongly recommended that joint liaison structures be established in all areas where they are outstanding.*

Good working requires not merely liaison, but also clarity as to who is doing what. This also helps to ensure accountability. A number of reasons have been offered why joint action sheets are not in operation. For example, it is clear that there was an industrial relations issue regarding this in the former Eastern Regional Health Authority region. Some staff also believed that they served no purpose, particularly as due to Garda shift working, some actions might be taken by Gardaí at times when social workers were not at work. But, if anything, this underlines the importance of joint action sheets, since they also provide a way for each side to update the other of what was done on a case in the absence of the other.

The failure to operate joint liaison arrangements, formal notifications and joint action sheets in many parts of the State has the potential not only to weaken the implementation of Children First, but also to weaken the chances of the successful prosecution of offenders and the effective protection of children. *While this Office has no power to investigate an Garda Síochána, it is satisfied that in a number of instances – notably concerning joint action sheets and notifications – responsibility lies in particular with the HSE. To the extent that this flows from industrial relations difficulties, the lack of transparency regarding such difficulties involves unsound administration by the Department of Health and Children for reasons already stated. To the extent that it does not – and it appears that there are other reasons for non implementation of, for example, joint action sheets such as a belief that they serve no useful purpose - this Office believes that the failure to implement such important requirements is also an unsound administrative practice by the HSE within the meaning of s.8 of the Ombudsman for Children Act 2002, not least because the failure to coordinate Garda and HSE action is unlikely to ensure effective protection of children.*

This Office is also concerned at reports that Garda notifications are not being completed. This is a serious matter and it is recommended that the SSI and an Garda Síochána Inspectorate jointly inspect the extent to which this is the case.

Another concern expressed by Gardaí is that strategy meetings are too often not being held, or are being held too late. In some cases this results in the child and alleged perpetrator being interviewed without an Garda Síochána being notified. This has the potential to prejudice criminal investigations – for example by giving the abuser an opportunity to destroy evidence, such as hard drives, before they can be seized. However, there was little evidence of this other than the assertion of a senior Garda. This is not to say that the Garda is incorrect. But instead, *it is recommended that SSI and an Garda Síochána Inspectorate jointly inspect the implementation of Children First's requirements on Garda/HSE cooperation, including as regards the early holding of strategy meetings.*

Finally, one CCM expressed concern that he did not have access as of right to any list of convicted sex offenders kept by Gardaí in respect of his area. It should be noted in this regard that the Probation and Welfare Service will notify the CCM of any convicted sex offender being released into his or her area. However, a CCM raised with this Office the concern that on a number of occasions the offender had moved into the area *post-release* and the offender had been living in the area for some time before the relevant HSE Local Health Office became aware of this. The view of an Garda Síochána was that information can only be shared on a case by case basis where there is a risk and that giving a list of all convicted sex offenders, as such, would require legislative change.

The difficulty is that the assessment of risk to children is an important part of the HSE's work. While not within the terms of reference of this investigation, given the importance of the issue and given that it arose in the course of the investigation, *it is recommended that all necessary steps be taken to ensure that a list of all convicted sex offenders in the area can be given to HSE Local Health Offices so that they can assess risk to any children. It is also recommended that this be examined as part of the joint SSI/Garda Síochána Inspectorate inspection recommended above.*

vii. Commitment to record keeping

Children First stresses the importance of record keeping.[113]

Since this was an area of fundamental importance to good working, local procedures were assessed to see if they contained a clear requirement to keep records.

Local procedures that did contain such a commitment included **North Tipperary**, **Clare**, **Limerick**, **Roscommon**, **Laois/Offaly,**[114] **Dublin North West, Cavan/Monaghan** and **Meath.**

Local procedures that did not contain such a commitment (or cases where there were no local procedures) included: **Wexford, Waterford, South Tipperary**, **Carlow/Kilkenny**, **Cork West, Cork North, North Lee, South Lee, Kerry, Sligo/Leitrim, Galway, Mayo**, **Donegal**, **Dublin South West**, **Dun Laoghaire**, **Kildare/West Wicklow**, **Wicklow**, **Dublin North Central, Louth, Dublin South City, North Dublin, Dublin West, Dublin South East** and **Longford/Westmeath.**

This, of course, does not definitively indicate whether records are or are not being kept. **Wexford**, for example, subsequently confirmed that all records were kept on RAISE, the IT system in operation in its area. **Galway** and **Wicklow** also confirmed that written records were kept in compliance with Children First's requirements. However, it is also clear from other parts of this report that record keeping has been prejudiced by an industrial relations dispute in some former Eastern Regional Health Authority areas.

[113] See e.g. para 8.4.
[114] This was mentioned in training slides.

It is recommended that record keeping be sufficient to record decisions taken and to guide future actions and that sufficient resources be put in place to ensure this.

It is recommended also that practices regarding record keeping be inspected by SSI.

CHAPTER V. MISCELLANEOUS ISSUES

There are a number of miscellaneous issues that are worth brief mention.

(a) Transfer

According to **Wicklow**, at least one area has refused to accept transfer applications until they had sufficient resources to allocate them even though the distance made it totally impractical for Wicklow to retain the cases on their books.

It is recommended that SSI, when it resumes inspection of child protection services, inspect in particular implementation of protocols on the transfer of files.

(b) Information Sharing and reporting

A number of CCMs recorded their view that information sharing from other professionals was not happening as envisaged by Children First. One commented:

> "The interpretation of confidentiality as outlined in Children First: "Giving information to others for the protection of a child is not a breach of confidentiality" is not always understood or accepted. Particular difficulties have been encountered with both adult and child and adolescent mental health services and psychiatrists... and some educational services."

Another expressed particular concern that a large number of retrospective allegations had not been passed on by a funded organisation providing services to young people. These related to sexual abuse, physical abuse and matters related to vaccination. A number of these related to the same alleged abusers.

Another professional commented to the OMCYA review expressed concern at the comments of a consultant that data protection legislation, rather that Children First guidance, would guide information sharing.

This being so, *it is recommended that the High Level Group provide further guidance on information sharing and data protection*. This should not await any forthcoming legislation on this issue.

It is also recommended that the HSE provide further training to professionals on their duty to report abuse, including retrospective cases.

(c) The wider context

It would be wrong to end this report without referring to the wider context in which social workers operate.

The number of social workers in the State increased from 1390.3 to 2237.5 between 1999 and 2005. That is an increase of 61%. This might lead one to believe that Ireland now has large amounts of social workers.[115] However, it appears that Ireland was starting from a low base and the State still falls far behind its nearest neighbours. The Irish rate is one social worker per 1,828.6 persons. In Northern Ireland, the figure is one social worker per 660.6 persons. In Scotland it is one social worker per 962 persons and in Wales one social worker per 1,325 persons.[116]

This Office therefore welcomes the commitment in the Ryan implementation plan to fill up to 270 posts currently vacant, but notes that this will still leave the number of social workers well below that of, for example, Northern Ireland.[117]

In such circumstances, this Office stresses that the adverse findings of this report should not generally be taken as an indication of lack of commitment by social workers.

[115] See Social Work and Family Support Survey, Health Service Executive, April 2009, (unpublished) at p.213.
[116] Social Work and Family Support Survey, Health Service Executive, April 2009, (unpublished) at p.30. These figures date from 2005.
[117] See Action 58 of the Ryan Report Implementation Plan, OMCYA, July 2009, available at http://www.omc.gov.ie/viewdoc.asp?fn=/documents/Publications/Implementation_Plan_from_Ryan_Commission_Report.pdf, retrieved on 15 January 2010.

CHAPTER VI. ADVERSE EFFECT

In order to initiate a full investigation this Office must conclude that a child *may* have been adversely affected by an action or inaction of a public body – in this case the HSE and the Department of Health and Children through OMCYA.

It is clear in this investigation that children may have been adversely affected by matters such as:

- the failure to adopt local procedures required by Children First,
- the failure to adopt consistent definitions required by Children First,
- the failure to adopt the basis for reporting required by Children First,
- the failure to ensure 24 hour access to the Child Protection Notification System required by Children First,
- the failure to establish formal HSE/Garda liaison arrangements required by Children First,
- the failure to conduct internal audits involving examination of casefiles

in many parts of the State, as well as -

- the overall failure in the period 2003 up to, but not including, 2008 to drive forward interagency working sufficiently on Children First,
- the overall failure of the HSE to drive forward implementation within that organisation sufficiently from its creation up to February 2009

the fuller details of which are set out earlier in this report.

Given that this is a systemic investigation, no recommendations are made for individual redress. In those circumstances, it is unnecessary for this Office to conclude whether the above failings leading to findings of unsound administration – or others set out in this report – in fact adversely affected a child or children. What is more important is that these matters are resolved for the future.

However, as a matter of common sense some of the above failings – in particular those around driving forward implementation generally and ensuring 24 hour access to the Child Protection Notification System and interagency working in particular – in all likelihood have adversely affected children in the State.

It is very much to be hoped that every effort will be made to ensure that these failings are remedied, so that child protection practice will be improved for the future. This Office will seek an update on progress in this regard in one year's time in order to assess progress to this end. Normally, this Office would seek an update in six months, but it is recognised that the issues raised by this systemic investigation are many and complex, and will take a longer period to address.

CHAPTER VII. CONCLUSIONS

(a) Findings

1. The Review of Adequacy 2008 conducted by the HSE is contrary to sound administration within the meaning of s.8 of the Ombudsman for Children Act 2002 as the HSE failed to ensure determination of adequacy in any meaningful way in each of its functional areas.

2. This Office concludes that the failure in the period from 2003 up to (but not including) 2008 to put in place appropriate mechanisms to drive forward interagency implementation of Children First involved unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002. Responsibility for the unsound administration as regards interagency matters lay with the Department of Health and Children to the extent that it related to problems such as with Garda/HSE cooperation, variable implementation by health boards in the period prior to the creation of the HSE and the failure to ensure interagency cooperation more generally – for example through Local Child Protection Committees and Regional Child Protection Committees.

3. Separately, up until the establishment of a HSE Taskforce in February 2009, this Office concludes that insufficient efforts were made to drive forward implementation of Children First by the HSE internally, such as failure to ensure that Local Health Offices had local procedures, and that this involved unsound administration by the HSE in the period since its creation.

4. In the period from the disbandment of the Health Boards Executive Resource Team in late 2002 to the disbandment of the Health Boards themselves on 1 January 2005, this Office concludes that there was unsound administration by the Health Boards in failing to resolve collectively problems that had arisen with Children First, including regarding its variable implementation.

5. This Office concludes that the failure by the HSE (and the Health Boards before 1 January 2005[118]) to put in place appropriate quality assurance through internal audit of casefiles more widely than in one part of the State (Cork/Kerry) and more frequently than once in a decade involves unsound administration and is therefore within s.8 of the Ombudsman for Children Act 2002, especially having regard to the worrying nature of the findings of the Cork/Kerry audit.

6. This Office concludes that the HSE in failing to ensure that Local Health Offices all have local procedures acted contrary to sound administration within the meaning of s.8 of the Ombudsman for Children Act 2002.

[118] With the exception of the *Southern Health Board*.

7. This Office believes that in its analysis of submissions to the OMCYA review and in the OMCYA review document itself proper mention should have been made of the real industrial relations issues that had arisen in the former Eastern Regional Health Authority region, given their effects on the ground. This Office concludes that the failure to be transparent about the industrial relations dispute in the OMCYA review and analysis of submissions involved unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002 on the part of the Department of Health and Children through the OMCYA.

8. The failure to ensure consistent definitions of abuse in local procedures across the HSE involves unsound administration by that public body within the meaning of s.8 of the Ombudsman for Children Act, 2002.

9. The failure to ensure clarity and consistency regarding the basis for reporting child abuse concerns across the HSE in local procedures involves unsound administration within the meaning of s.8 of the Ombudsman for Children Act, 2002.

10. This Office believes that the failure of the HSE to ensure 24 hour external access to the Child Protection Notification System in most of the State involves unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002.

11. While this Office has no power to investigate an Garda Síochána, it is satisfied that in a number of instances – notably concerning joint action sheets and notifications – responsibility lies in particular with the HSE for the failure to implement the requirements of Children First on Garda/HSE cooperation. To the extent that this flows from industrial relations difficulties, the lack of transparency regarding such difficulties involves unsound administration by the Department of Health and Children for reasons already stated. To the extent that it does not – and it appears that there are other reasons for non implementation of, for example, joint action sheets such as a belief that they serve no useful purpose - this Office believes that the failure to implement such important requirements is also an unsound administrative practice by the HSE within the meaning of s.8 of the Ombudsman for Children Act 2002, not least because the failure to coordinate Garda and HSE action is unlikely to ensure effective protection of children.

(b) Recommendations

1. **That resources be better matched to need around the State in social work departments to ensure equitable service provision through evidence based resource allocation.**

Response of HSE
Equitable services provision through evidenced based resource allocation was very much the focus and one of the key outcomes of the HSE Task Force Sub –Group: National Social Work and Family Support Survey Report and in conjunction with the

Ryan Report Implementation Plan will address deficits in relation to social work resources being better matched to need. The HSE National Service Plan 2010 also commits to an audit of resources targeted at children and families across the statutory and non-statutory sector and the recruitment of an additional 200 social workers for Child Protection and Alternative Care Services will be targeted at areas of greatest need.

Response from OMCYA
An audit of resources targeted at children and families across the statutory and non-statutory sector is one of the HSE led actions set out in the Government's Implementation Plan for the findings of the Ryan Commission recommendations and is included in the HSE Service Plan for 2010. The 2010 Employment Control Framework for the HSE includes provision for the recruitment of an additional 200 social workers for child protection services, as well as a further 65 posts in respect of the Ryan Report Implementation Plan (the required funding has also been provided to the HSE). The filling of these posts will be a matter in the first instance for the National Care Group Lead for Children in consultation with this Department and the Department will work to ensure that these posts are allocated in a way which takes account of service needs. It is envisaged that the audit of existing resources, referenced above, along with the improvements being made by the HSE in relation to standardised processes and management information, will provide a basis for the development of a more evidence-based allocation of available resources. This issue will also be considered further by the Department following receipt of the forthcoming report of the Resource Allocation Group.

2. **Given the well documented cases of clerical child sex abuse and the systemic failure to report such cases, that the application of the revised Children First Guidelines to churches be made explicit in the Guidelines themselves.**

Response of OMCYA
You are correct in pointing out that the revised Children First Guidelines state that the guidelines are for organisations providing services to children. However, they go beyond this in stating that they apply to organisations "in regular contact with children". As such there can be little doubt that the Guidelines apply to churches and are clearly not limited to organisations providing "services" to children. This is set out in Chapter 1 of the revised Guidelines. However, in order to avoid any risk that the revised guidelines might be misinterpreted they have now been expanded upon in Chapter 1 to clarify that they apply to voluntary and community groups including all faith based organisations. These amendments have now been incorporated in the final text for printing.

3. **It is important that family support services, locally and nationally, are properly planned for with appropriate strategies in place and it is recommended that all necessary steps be taken to this end, whether under the auspices of the revised Children First Guidelines or not.**

Response of HSE

An HSE specific action under the Ryan Implementation Plan commits to "all agencies that provide services to children and families develop and implement an operational plan based on the The Agenda for Children's Services." The HSE Strategy to support the Agenda for Children's Services was completed in 2009 and the National Service Plan 2010 advances implementation of the strategy in line with Task Force outputs. An operational plan is currently being finalised by the HSE in relation to the development of Family Support Services incorporating an action plan to improve our engagement with children and young people and we are in the process of finalising the "Investing in Parents and Children's Strategy which will clearly outline the targeting of prevention and early intervention services. There will also be a requirement built into all local Service Level Agreements with all community and voluntary agencies that are funded and provide services to children and families of the necessity to develop and implement an operational plan based on the Agenda for Children's Services.

Response of OMCYA

The OMCYA is committed to the future development and enhancement of family support services in line with Government policy set out in The Agenda for Children's Services.

4. **This Office is aware that the HSE is undertaking a Strategic Review of the Delivery and Management of Child Protection Services. It is important that this review considers all options and asks new questions. That should include whether child protection services are best delivered within the context of the HSE and, if concluded that they are, how to ensure that a focus on them is not lost amid wider concerns about health services.**

Response of HSE

Focus on the delivery and management of Child Protection Services is underpinned by the creation of the Children and Families Care Group and the appointment of the Assistant National Director. This is enhanced by the Ryan Implementation Plan; "The HSE will act to reform its management structures following the review it commissioned in July 2009 to ensure a transparent and accountable management system, confirmed in the 2010 Service Plan, with the implementation of the "Strategic Review of Child Protection Services"

5. **It is strongly recommended that the High Level group established by the OMCYA meet to resolve all outstanding interagency policy issues regarding Children First identified in the context of the OMCYA review.**

Response of OMCYA
This recommendation will be addressed in the context of the structures to be put in place as part of the implementation framework referred to above.

6. **It is recommended that SSI, upon recommencing inspection of child protection work and consistent with its normal practice in other fields, examine case files to get a true picture of the state of implementation in practice.**

Response of OMCYA
It is doubtful if the previous SSI role could be validly described as "inspection of child protection work". As outlined on page 20 of your report an inspector of the SSI was appointed to monitor the implementation of Children First. The subsequent report from the SSI was informed by meetings with key stakeholders and information collated by way of health board questionnaires. However, this recommendation will be addressed in the context of the action referred to above, i.e. that the Social Services Inspectorate of HIQA "develop standards and commence inspection of child protection and welfare services (by September, 2011)."

7. **That efforts be made on all sides to resolve all outstanding industrial relations issues affecting the implementation of Children First.**

No response received from HSE in relation to this recommendation.

Response of OMCYA
This is a matter in the first instance for the HSE as employer but the Department of Health & Children will provide the HSE with any support and assistance which is necessary to ensure this matter is addressed, particularly in the context of the information provided in your report and the opportunity presented by the revised Guidelines.

8. **It is strongly recommended that work to standardise processes and improve datasets by the HSE be continued as a priority. This should include clarity on screening and initial assessments, clarity on when to accept to the Child Protection Notification System and when to close a case to the Child Protection Notification System, as well as clarity on the non-removal of cases from the Child Protection Notification System.**

Response of HSE

The National Child Care Information System with concomitant Standardised Business Processes has been prioritised by the HSE for implementation subject to approval by the Department of Finance and is included in the HSE National Service Plan 2010.

9. It is recommended that all necessary steps be taken to ensure that information be stored and searchable otherwise than solely on grounds of alleged victim, at least prospectively if it is not feasible to do so retrospectively.

Response of HSE

The HSE commits to address information retrieval systems to include the Ombudsman's recommendations in addition to development of a National Archive managed professionally for the records of all children in care including records from non-statutory agencies.

10. **While this is not a requirement of Children First, given the reality that families and children can move between counties, it is recommended that consideration be given to the creation of a national the Child Protection Notification System system, rather than only a local one.**

Response of HSE

The HSE will give consideration to the creation of a National Child Protection Notification System System. In addition a cross border working party under the auspices of the North / South Ministerial Conference is currently devising a protocol in relation to the movement of vulnerable children and families across jurisdictions.

11. **While not a requirement of Children First, this Office strongly recommends the rolling out of an out of hours service throughout the State and that all necessary funding be given priority to this end.**

Response of HSE

Ryan Implementation Plan actions; subject to funding, the HSE putting in place a national Out of Hours Social Work Crisis Intervention Service built into the existing HSE Out of Hours Service. This will be piloted initially in two areas of the country.

Response of OMCYA

One of the actions in the Ryan Implementation Plan is that "The HSE will put in place a national out-of-hours social work crisis intervention service, built into the existing HSE out-of-hours service. This will be piloted initially in two areas of the country"

12. **It is noted that the current role of CCMs is under review and it is recommended that issues of access to information by the CCM or designate and ability to direct be fully considered in that context.**

Response of HSE
The role of Child Care Managers is actively under review and is a key management reform component of the structural management and accountability process.

13. **This Office can see merit in the proposal for a dedicated child protection service in an Garda Síochána and recommends consideration of this proposal.**

14. **It is strongly recommended that joint liaison structures be established between the HSE and the Garda Síochána in all areas where they are outstanding.**

Response of HSE
In order to advance and enhance joint working arrangements between the HSE and An Garda Siochana a recent high level meeting was convened by the Assistant National Director, Children and Families Social Services, with Gardai at Assistant Commissioner level identifying key areas including joint liaison structures to address deficits. This work is ongoing.

15. **Reports that Garda notifications are not being completed are a serious matter, and it is recommended that the SSI and an Garda Síochána Inspectorate jointly inspect the extent to which this is the case.**

16. **It is also recommended that SSI and an Garda Síochána Inspectorate jointly inspect the implementation of Children First's requirements on Garda/HSE cooperation more generally, including as regards the early holding of strategy meetings.**

Response of OMCYA
These recommendations [15 and 16] *will be addressed as part of the implementation framework referred to above and, in particular, the action in the Ryan Implementation Plan to the effect that compliance with the Children First guidelines be linked to all relevant inspection processes across the education, health and justice sectors.*

17. **It is recommended that all necessary steps be taken to ensure that a list of all convicted sex offenders in the area can be given to each Local Health Office so that it can assess risk to any children. It is also recommended that current practice in this area be examined as part of the joint SSI/Garda Síochána Inspectorate inspection recommended above.**

18. **It is recommended that record keeping be sufficient to record decisions taken and to guide future actions and that sufficient resources be put in place to ensure this.**

Response of OMCYA
The record keeping requirements, as provided for in Children First, will be addressed as part of the implementation framework referred to above.

19. **It is recommended that practices regarding record keeping be included in future inspections by SSI.**

20. **It is recommended that SSI, when it resumes inspection of child protection services, inspect in particular implementation of protocols on the transfer of files.**

Response of OMCYA
These recommendations [19 and 20] *will be addressed in the context of implementing the action in the Ryan Report Implementation Plan to the effect that the Social Services Inspectorate of HIQA "develop standards and commence inspection of child protection and welfare services (by September, 2011)."*

21. **It is recommended that the High Level Group provide further guidance on information sharing and data protection. This should not await any forthcoming legislation on this issue.**

Response of OMCYA
This recommendation will be addressed as part of the implementation framework referred to above. In addition, considerable work is currently being undertaken on this issue with regard to legislation.

22. **It is recommended that the HSE provide further training to professionals on their duty to report abuse, including regarding retrospective cases.**

Response of HSE
The HSE is committed to the ongoing professional development of staff including training for professionals moving into management positions. A National Steering Group representing the Health, Education and Justice sectors to strategically plan for the training needs of staff working with children and families is being established and will target priority areas under the auspices of the National Steering Group.
A National Specialist with responsibility for training has been designated to lead out on this process and child protection has been designated as a key priority.

POSTSCRIPT

This Ombudsman for Children is obliged by statute to provide an opportunity to comment before certain adverse findings are made.

Accordingly, on 15 February 2010 this Office sent a draft of its report to the OMCYA and the HSE and to others on 18 February 2010. Comments were received from each, which were duly considered before the report was finalised.

The final report was sent to the OMCYA and HSE on 1 April 2010 in order to allow the OMCYA and HSE to respond to the 22 recommendations of the report.

Responses were duly received from the OMCYA and HSE and these have been included also in the final report. However, the OMCYA at this stage also made some substantive points about the findings of the report. In particular, these challenged the fairness of the finding that:

> "This Office believes that in its analysis of submissions to the OMCYA review and in the OMCYA review document itself proper mention should have been made of the real industrial relations issues that had arisen in the former Eastern Regional Health Authority region, given their effects on the ground. This Office concludes that the failure to be transparent about the industrial relations dispute in the OMCYA review and analysis of submissions involved unsound administration within the meaning of s.8 of the Ombudsman for Children Act 2002 on the part of the Department of Health and Children."

It is unusual for the Office to receive representations from a public body at this late stage of an investigation. This usually takes place in response to the opportunity afforded to the OMCYA in February 2010. However, in the overriding interests of fairness, the Ombudsman for Children nonetheless chose to do so on a wholly exceptional basis.

In the OMCYA response it was asserted that there were references in just 4 out of 136 submissions to the industrial dispute, being those referred to at pages 33-34 of this report. In earlier correspondence, the OMCYA suggested that there had been only five quotes relating to the industrial dispute or industrial relations.

However, this Office has identified seven submissions which mention trade union or industrial relations issues. Further, there were seventeen separate quotes regarding these matters. This Office cannot exclude that there were further submissions which raised these matters, as not all submissions were submitted to us for examination.

This Office stresses, however, that it is not merely the number of submissions that is important; it is also the significance of the professionals who made the submissions. We have already cited at page 34 the professional experience of those who made four of those submissions. In addition, industrial relations issues were raised by:

- an individual former Child Care Manager in the former ERHA region,
- a collective submission made by every Child Care Manager in the State,
- A Board involved in public health issues in the ERHA region.

In all of those submissions, the matter was raised under question 1, arguably the most important question, which asked consultees "Overall in your experience, are the Children First Guidelines working well?"

The OMCYA also argued that in its analysis of submissions it could not take into account anecdotal or additional information which may have been available outside of that contained within the text of the submissions. This Office can accept this, but is nonetheless of the view that the matter should have been referred to in the review published in 2008 in view of the number and nature of the submissions raised.

However, this Office would point out that the finding of unsound administration related to "the failure to be transparent about the industrial relations dispute in the *OMCYA review and analysis of submissions*." There was nothing to prevent the Department of Health and Children, in the context of the *OMCYA review* itself, having regard to the results of the survey of implementation of Children First that it had previously conducted in 2003/04. That survey clearly and repeatedly identified industrial relations issues in the ERHA region. Indeed, it would have been entirely fitting for the Department to use the information which it had already acquired. It did not do so.

Had the industrial relations issue been mentioned in the OMCYA review itself, its omission in the analysis of submissions would not have warranted a finding of unsound administration. It was the failure to mention the matter *at all* that breached the principle of transparency and led to the finding of unsound administration.

Finally, the Department pointed out that problems of implementation were endemic across many different health board areas and that they were neither confined to, nor exclusive to, the Eastern Regional Health Authority and that consequently it would have been invalid and lacking in rigour to conclude that all the issues arising in one region were as a consequence of an industrial relations issue but arose in all other regions for some other reason.

However, this Office has never suggested that problems of implementation were confined to or exclusive to the Eastern Regional Health Authority. Nor has this Office suggested that OMCYA should have concluded that all the issues arising in the ERHA region were as a consequence of industrial relations. What this Office has pointed to is that an industrial relations issue existed. That it was known to the Department of Health and Children. That it was raised as a barrier to implementation in at least seven submissions, many in very clear terms. And that in view of this the failure to mention it in the OMCYA Review and analysis of submissions involved unsound administration.

This Office holds to its finding.

ANNEX A

PRE-CHILDREN FIRST GUIDELINES FOR CHILD PROTECTION

In 1977 a *Memorandum on Non-Accidental Injury to Children* was issued, following the establishment of the first ever expert group on this issue.[119] That document introduced a multi-disciplinary approach to child protection, including case conferences. The Health Boards at local level were responsible for coordinating case conferences, which it was envisaged would involve medical personnel, social workers, teachers and, where appropriate, an Garda Síochána.[120]

The 1977 Guidelines were revised in 1980, and replaced in 1987 by a new document, entitled *Guidelines on Procedures for the Identification, Investigation and Management of Child Sexual Abuse*.

These Guidelines – from 1987 – were the first in the history of the State to deal specifically with sex abuse, the prevalence of which was stated to be "much greater than previously assumed."[121]

The 1987 Guidelines retained some of the key features of the 1977 Guidelines, such as the use of case conferences and the emphasis on interdisciplinary working. They mentioned the role of an Garda Síochána in outline only: No real guidance was given on how the relationship between the two was to work. That only came in 1995 with the publication of *Notification of Suspected Cases of Child Abuse between Health Boards and Gardaí*, issued by the Department of Health and an Garda Síochána.

The 1995 Guidelines supplement the 1987 ones. They cover much the same ground as provisions of Children First on Garda/HSE cooperation. However, there are some significant differences between Children First and the previous Guidelines:

- Children First covers private citizens, for profit organisations, voluntary and community organisations. The 1987 Guidelines do not cover any private citizens and mentions voluntary and community groups only fleetingly.

- Under the 1987 Guidelines the role of the Director of Community Care/Medical Officer of Health is central. But under Children First, the CCM has this role.

- The 1987 Guidelines are outdated: they do not explain the Child Care Act 1991 or the Protections for Persons Reporting Child Abuse Act, 1998, or other recent legislation relevant to child protection.

- Neither the 1987 Guidelines nor Children First introduce mandatory reporting. Both rely on goodwill or good administrative practice instead.

[119] Department of Health, Memorandum on Non-Accidental Injury to Children, 1977.
[120] See the Ferns Report delivered to the Minister for Health and Children in October 2005 at pages 53 to 56 for a history of child protection guidelines in Ireland.
[121] See the 1987 Guidelines at p.23.

- Children First is clearer on the basis for reporting – that is to say that there are reasonable grounds for concern, and explains what reasonable grounds for concern are. It is also clearer on how to report. And, unlike the 1987 Guidelines, it covers historic cases of abuse.

- The 1987 Guidelines require reporting through line management for public health nurses and Health Board workers. While Children First envisaged reporting through the designated person in each organisation, ultimately the obligation to report is an individual one.

- Unlike Children First, the 1987 Guidelines do not define neglect and emotional abuse. The 1995 Guidelines do, however, define these terms, albeit in slightly different terms to Children First. Importantly, the concepts are better explained through examples in Children First.

- Children First provides for Local Child Protection Committees and Regional Child Protection Committees. The 1987 Guidelines do not.

- Children First requires 24 hour access to the notification system – with all relevant services and agencies to have up to date information about arrangements for access. The 1987 Guidelines do not require this.

- Procedures for assessment are more elaborate in Children First, but not dissimilar to the 1987 Guidelines.

- The vehicle for interdisciplinary work under the 1987 Guidelines is the case conference. By contrast, under Children First provision is made for Strategy meetings, Child Protection Conferences, Child Protection Reviews, case management reviews and child protection notification management meetings.

- Children First has stronger requirements on record keeping than the 1987 Guidelines.

- The 1987 Guidelines do not have any provision on family support services.

- The 1987 Guidelines do not specifically address the need to share information, notwithstanding professional issues regarding confidentiality.

- The 1987 Guidelines do not contain any provisions on specially vulnerable children and abuse outside the home, peer abuse and allegations of abuse against employees and volunteers.

- The 1987 Guidelines have no provisions on training, supervision and support.

- The 1987 Guidelines have no provisions on localised procedures.

- The provisions on Garda cooperation in the 1995 Guidelines are very similar to those in chapter 9 of Children First. Perhaps the biggest difference is that Children First requires a middle tier of liaison between Gardaí and child protection workers – at the superintendent/inspector – social work team leader level. Also Children First

explicitly requires joint action sheets upon which the Garda and social worker designated to a case record the tasks that they will each undertake or have undertaken.

ANNEX B

GARDA/HEALTH BOARD COOPERATION – UNCLEAR ASPECTS

Paragraph 9.2.1 of Children First states:

> "It is essential that the Health Board and An Garda Síochána designate personnel at investigation and management levels who will remain involved with *the case* until the investigation is completed." [Emphasis added]

To this end, paragraph 9.2.2 proposes that "a social work Team Leader from the Health Board and designated district-based Inspector/Sergeant from within an Garda Síochána would constitute a liaison management team whose functions comprise the following:

(i) to consider *notifications*;

(ii) to assign personnel and supervise investigation (*sic*);

(iii) to review progress in the case." [Emphasis added]

The reference to notifications suggests that the liaison management team is not a team appointed for the purposes of an individual case, but a standing team to oversee joint cooperation more generally. But the reference to "the case" suggests the very opposite.

Paragraph 9.4.5 then states that Health Board to Garda Síochána notifications should go from the CCM/designate to the Superintendent and that the "Superintendent arranges to have a designated Garda assigned to the case." However, here too there is a lack of clarity as para 9.2.2 suggests that it is the liaison management team – operating at Inspector/Sergeant level - that assigns personnel.

Who precisely is to do what is therefore not clear.

ANNEX C

MAIN FINDINGS OF THE OMCYA REVIEW, 2008

The following are among the most significant findings of the OMCYA review and have been extracted from the Review report by this Office:

- There is a need to acknowledge the role of departments other than the Department of Health and Children.

- There is a need to expand the Garda vetting service to cover all children.

- There is a need for better involvement of parents and children.

- Sharing of information is not happening as envisaged because of constitutional and legal difficulties and communication difficulties between various professions, as well as IT difficulties.

- There is a need to make information available at the correct level e.g. basic information for the public, more for professionals.

- Appropriate and effective child protection policies, procedures and training should be put in place and reviewed regularly in all settings where services or activities are provided for children. Areas where shortcomings were identified included some after-school facilities, summer and holiday camps, and private entertainment provision for children.

- Direct and indirect funding from Government should be made contingent on compliance with child protection policies being in place.

- Organisations will require assistance in drawing up child protection policies and templates should be made available for that purpose and that demand for training and information will rise, including from parents.

- Procedures need to be put in place to ensure compliance with Children First.

- Additional safeguards are required for vulnerable children.

- Measures need to be taken to reduce the risks of child abusers reoffending, including the continued roll out of vetting, safe recruitment procedures, sharing of soft information and improved treatment of abusers, particularly young abusers.

- Persons seeking to raise child protection concerns need to be facilitated, for example by ensuring the availability of staff, clear points of contact, a protocol about feedback and further detail on the HSE website. A key issue was also out of hours services.

- The Child Protection Notification System (and other systems developed locally) were still problematic. In particular, access to information on the register is not readily available outside the child protection social work service. A new service therefore needed to be devised.

- There was a concern that children suffering from neglect are least well served by the current child protection system and that the focus is not on long term identified needs.

- The initial impetus for implementing Children First lost momentum.

- Current regional and local child protection committees were not working effectively.

- The High Level Group established following the Dr A inquiry provided a mechanism for dealing with child protection issues at national level.

ANNEX D

MAIN DIFFERENCES BETWEEN CHILDREN FIRST 1999 AND CHILDREN FIRST 2010

Overall Assessment

Overall, the revised Guidelines are very similar to Children First 1999. The revised Guidelines involve less repetition. And some important issues have been clarified. But, significantly, there are also cases were standards have been reduced compared to Children First.

Summary of key differences

- There is a new "**key messages**" section to get the basics of child protection across in a nutshell. This is useful.
- The Guidelines can more easily be interpreted as applying to **churches**, but it is still unclear. Nowhere is it mentioned explicitly that they apply to churches as such.
- It is clarified that abuse should be reported even if the child is **unidentifiable**. But the implications of this are not worked through in the rest of the guidelines. The point made by the Murphy Commission regarding the need for searching to be possible by name of alleged abuser as well as by name of alleged victim will need to be taken forward.
- There is no mention of **Regional Child Protection Committees or Local Child Protection Committees**. Instead, it is stated that the cooperation is required at national, regional and local level by the key stakeholders and, separately, that the HSE may redesign its procedures. (The OMCYA review found that both structures were not working effectively and recommended that the HSE review them and replace them if necessary and put in place an appropriate structure to facilitate effective child protection across the HSE. But no replacement is included in the new guidelines.)
- There is no requirement for **family support service plans**, to plan family support services at local level. This is surprising given the OMCYA review recommendation that early intervention and family support services be strengthened.
- Reference is made to **new statutory bodies**, e.g. HIQA, the National Educational Welfare Board and the Ombudsman for Children.
- The new Guidelines distinguish more clearly between preliminary enquiries and **initial assessment**. They also make clear that initial assessment should happen before notification to the Child Protection Notification System. This is important as there had been confusion on these issues under the old Children First, although Health Boards Executive had sought to clarify them in 2002.

- It is clarified that it is the **Child Protection Notification Management Meeting** that decides on acceptance to the Child Protection Notification System, not the CCM. The old Guidelines were silent on this point and practice varied across the State.

- Like the old Guidelines, there is no clarity about how a case is **closed to the Child Protection Notification System**. By contrast, the Health Boards Executive in their guidance on the Child Protection Notification System clarifies that "whilst it is not possible to delete a child's record from the Child Protection Notification System, a case is to be closed to the Child Protection Notification System when the risk to the child is removed or reduced." It is regrettable that new Guidelines do not clarify this area, where there is divergent practice. However, this may be covered in the HSE's standardised procedures.
- Significantly, a **serious incident report** (formerly known as a case management review) will no longer be needed into the death or serious injury of a child if the child was never known to the child protection services. This is so even if other parts of the HSE were aware that the child was abused or the child's school or GP were aware.
- The former requirement that **investigation into abuse in residential care** should be carried out by a senior member of the HSE's staff who does not have immediate line management responsibility for the home and should include an independent person is not reproduced in the new Guidelines.
- There is no clear and explicit requirement on **Local Health Offices to have local procedures**. Formerly it was required that all health boards have them.